Supreme Court, U.S.
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No. _____

IN THE

Supreme Court of the United States

COOKEVILLE REGIONAL MEDICAL CENTER, ET AL.

Petitioners,

v.

MICHAEL O. LEAVITT, SECRETARY, DEPARTMENT OF HEALTH & HUMAN SERVICES

Respondent.

On Petition For A Writ Of Certiorari To The United States Court of Appeals for the District of Columbia Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

This petition presents two questions on which there is a recognized conflict in the decisions of the Courts of Appeals:

1. Whether a court may avoid the presumption against retroactivity and the due process analysis set forth in *Landgraf v. USI Film Products*, 511 U.S. 244 (1994), based on its own view that a statutory amendment is a "clarification" of an existing law?

2. Whether reliance on a pre-amendment statute is a necessary element of a challenge to the retroactive application of the amended statute under *Landgraf v. USI Film Products*, 511 U.S. 244 (1994)?

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

The petitioners are Cookeville Regional Medical Center, Gateway Health System, Blount Memorial Hospital, University of Tennessee Memorial Hospital, Sycamore Shoals Hospital, Middle Tennessee Medical Center, St. Mary's Health System, Fort Sanders Regional Medical Center, Fort Sanders Loudon Medical Center, Fort Sanders Parkwest Hospital, Methodist Medical Center of Oak Ridge, Johnson City Hospital Medical Center, Jackson-Madison County General Hospital, Vanderbilt University Medical Center, St. Thomas Hospital, Baptist Memorial Hospital, Inc., Baptist Memorial Hospital – Tipton, Baptist Memorial Hospital – Union City, and Baptist Memorial Hospital – Desoto. The respondent is the Secretary of the United States Department of Health and Human Services.

Pursuant to this Court's Rule 29.6, undersigned counsel state that Petitioners Cookeville Regional Medical Center, et al., and Baptist Memorial Hospital Inc., et al., are not-for-profit corporate entities. There is no parent company, subsidiary, or affiliate of any Petitioner that has outstanding securities in the hands of the public, and there is no publicly held corporation that owns 10 percent or more of the stock of any Petitioner.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners respectfully submit this petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the District of Columbia Circuit.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the District of Columbia Circuit is published at 531 F.3d 844 (D.C. Cir. 2008). App. 1a-11a. The Orders of the United States District Court of the District of Columbia, which were the subject of appeals to the D.C. Circuit, have not been published in the official reporters, but one can be found at 2006 WL 2787831. App. 12a-29a. The district court's prior related order has not been published in the official reporters, but can be found at 2005 WL 3276219. App. 30a-47a.

JURISDICTION

The United States Court of Appeals for the District of Columbia Circuit entered judgment on June 27, 2008. The time for filing this petition was extended to October 27, 2008 by the Chief Justice's Order. No. 08A226 (Sept. 15, 2008). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Fifth Amendment to the U.S. Constitution provides, in relevant part:

> No person shall be ... deprived of life, liberty or property, without due process of law ...

U.S. Const. amend. V, § 1.

The statutory provisions and regulations involved in this appeal are set forth in the Appendix.

STATEMENT

Prior to 2005, the Medicare statute provided that the days spent in a hospital by patients eligible for Medicaid because of an expansion waiver granted under Section 1115 of the Social Security Act were included in calculating the Medicare reimbursement for hospitals that serve a disproportionate share of low income patients. Congress, the Secretary of Health and Human Services, and the courts had issued statements and rulings confirming this inclusion. The fiscal intermediaries responsible for Petitioners' Medicare reimbursement nevertheless refused to include expansion waiver days in the relevant calculation. Petitioners sued and the district court agreed that the controlling statutory scheme unambiguously required that those days be included.

While the Secretary's appeal was pending, Congress passed the Deficit Reduction Act of 2005 (DRA), which changed the legal status of expansion waiver populations, making the inclusion of expansion waiver days optional at the Secretary's discretion. The United States Court of Appeals for the District of Columbia Circuit held that the DRA, which contained no congressional authorization for retroactive application, could be applied retroactively. That

ruling cost the Petitioners more than $54 million for treatment delivered, plus statutory interest.[1]

The DRA's retroactive application implicates important issues of constitutional significance—most fundamentally the application and scope of the presumption against retroactivity set forth in *Landgraf v. USI Film Products*, 511 U.S. 244 (1994), and reinforced in *Hughes Aircraft Company v. United States*, 520 U.S. 939 (1997), and *INS v. St. Cyr*, 533 U.S. 289 (2001). The Courts of Appeals have not applied the reasoning in these decisions consistently and there are multiple appellate opinions noting the disagreements. This Court's intervention is needed to restore uniformity on when and how *Landgraf's* retroactivity analysis should be invoked.

I. The Medicare Statute's Treatment Of Expansion Waiver Days Prior To 2005.

The Medicare statute authorizes an adjustment in reimbursement to hospitals that provide in-patient treatment to a disproportionate share of low-income patients. *See* 42 U.S.C §1395ww(d)(5)(F)(i)(I). Before 2005, the statute unambiguously stated that this "disproportionate share hospital" (DSH) adjustment was to be based in part on the total number of days the hospital spent providing treatment to low-income patients eligible for medical assistance under Title XIX

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[1] Hospitals all over the country are eligible for Medicare reimbursement when they treat those who are poor and elderly, and some are still litigating in various judicial districts over the inclusion of expansion waiver days for periods prior to the effective date of the DRA.

(Medicaid). *Id.* §1395ww(d)(5)(f)(vi)(II). Despite the statutory directive, fiscal intermediaries nevertheless treated Medicaid-eligible "patient days" in different ways. App. 33a-34a (*Cookeville I*). Some routinely included patient days attributable to so-called "expansion waiver populations"—*i.e.*, patients who were eligible for Medicaid because they were involved in a "demonstration project" approved by the Secretary under Section 1115 of the Social Security Act, 42 U.S.C. §1315a(1)-(2). *Id.* Others, including those responsible for Petitioners' Medicare claims, did not. *Id.*

On January 20, 2000, the Secretary issued an interim final rule addressing the fiscal intermediaries' differing approaches. App. 53a-67a. In the rule, the Secretary purported to (1) state his policy regarding DSH calculations for periods prior to January 20, 2000 and (2) announce a "change" in policy for DSH calculations in the future. *Id.* Although the Secretary stated that expansion waiver days should have been excluded from DSH calculations prior to January 20, 2000, he also indicated that he would not seek to recover payments made to hospitals where those days had been included in DSH calculations for that period.

The Secretary also announced a change in policy that would require fiscal intermediaries to include expansion waiver days in DSH calculations after January 20, 2000. The Secretary acknowledged that "[o]ne of the purposes of a section 1115 expansion waiver is to extend Title XIX matching payments to services furnished to populations that otherwise could not

have been made eligible for Medicaid." *Id.* The Secretary stated that the inclusion of persons made "eligible for [Medicaid] matching payments under a section 1115 waiver" was "fully consistent" with the goals of the DSH adjustment. *Id.*

II. The District Court Rules That The Medicare Statute Unambiguously Requires Inclusion Of Expansion Waiver Days In Petitioners' DSH Calculations.

Petitioners filed an action against the Secretary to recover more than $54 million, plus statutory interest, attributable to the exclusion of expansion waiver days for fiscal years 1994 through 2000. The district court entered summary judgment in Petitioners' favor, finding that (1) the Medicare statute unambiguously required inclusion of expansion waiver days when calculating Petitioners' Medicare DSH adjustments and (2) the relevant statutes did not provide the Secretary with any authority to exclude expansion waiver days from those adjustments. App. 30a-47a. The district court was not the first court to so hold. In *Portland Adventist Medical Center v. Thompson*, 399 F.3d 1091 (9th Cir. 2005), a panel of the Ninth Circuit unanimously affirmed a judgment requiring the Secretary and fiscal intermediaries to include expansion waiver days when calculating Medicare DSH adjustments.

III. After Passage Of The Deficit Reduction Act of 2005, The District Court Reopens Its Judgment And Finds That The DRA Changed The Treatment Of Expansion Waiver Days Retroactively.

The Secretary appealed the adverse judgment, but while the appeal was pending, Congress passed the DRA, Pub.L. 109-171. Section 5002(a) of the new law amended the statutory formula governing Medicare DSH calculations, making inclusion of expansion waiver days optional at the Secretary's discretion. App. 51a-52a. Section 5002(b) did not amend any part of the Medicare statute; instead, it purported to "ratif[y]" the Secretary's 2000 rule. *Id.* §5002(b).

While his appeal was still pending, the Secretary moved the district court, pursuant to Rule 59(e), to alter or amend the judgment based on the DRA. The district court opined that the Secretary's motion would be granted if the appellate court remanded. App. 13a. In a memorandum opinion, the district court reconsidered its original ruling in light of §5002. The court rejected the Secretary's argument that the DRA simply clarified the original text of the statute governing DSH calculations.

> I remain of the view that the DSH formula, as it existed at the time of the cost reports at issue, expressly included expansion populations. That formula referred to all patients eligible for Title XIX medical assistance, and expansion populations' medical expenses are

> reimbursed from funds allocated under Title XIX. The DRA's insertion of the phrase "not so eligible" into the formula did not "clarify" this simple equation—it simply changed it. *See U.S. v. Montgomery County, Md.*, 761 F.2d 998, 1003 (4th Cir. 1985) ("[A] statute which has all along unambiguously proclaimed WHITE cannot retrospectively be made to assert BLACK just because the legislature, at the later date, says so.").

App. 23a. The court further noted that the DRA's purported "clarification" was contradicted not only by the unambiguous language of the pre-DRA statute, but also by laws enacted in the 103rd and 105th Congresses, which expressly read the pre-DRA Medicare statute as requiring inclusion of expansion waiver days in DSH calculations. App. 24a-25a (citations omitted).

Having found that the DRA made a "substantive change to the statutory DSH formula," the court next analyzed whether this substantive change could be applied retroactively. *Id.* The court was "mindful of the heavy presumption in the law against the retroactive application of statutes and the rule that courts will only apply a law retroactively if there is a clear statement in the statute requiring that result." App. 25a-26a (citing *Rivers v. Roadway Express*, 511 U.S. 298, 307-310 (1994)). The court concluded, however, that the DRA embodied a "clear statement" of Congress's intent to have the change apply retroactively because (1) Congress

used the term "clarification" in the title of Section 5002 of the DRA; and (2) Congress purported to ratify the Secretary's 2000 final interim rule. App. 26a-28a. Then, after remand from the Court of Appeals, the district court entered a new judgment in the Secretary's favor. [2]

IV. The Court Of Appeals Affirms Finding That The DRA Can Be Applied Retroactively.

Petitioners appealed that revised judgment, arguing that the pre-DRA statutory scheme unambiguously required the Secretary to include expansion waiver days in Petitioners' DSH calculations; that the DRA, therefore, did not clarify the DSH formula, but instead substantively changed it; and that such a substantive change could not be applied retroactively under *Landgraf* and its progeny because Congress had not clearly mandated such a retroactive application.

Unlike the district court, the D.C. Circuit did not begin its analysis by asking whether Congress had clearly expressed its intent that the DRA apply retroactively. Instead, the panel began by asking whether Petitioners had relied on the language of the pre-DRA statutes when they provided care to expansion waiver populations. App. 7a-8a. Without focusing on the text of the

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[2] The four Baptist hospital petitioners were litigants in a separate action that, on appeal, was argued and decided together with the Cookeville hospital petitioners' appeal. The district court had entered its decision in the Baptist hospitals' action based upon its entry of judgment in the Cookeville action. App. 1a-2a, 12a.

pre-DRA statute itself, the panel declared that the statute was "unclear." App. 7a-11a. Then, having made that declaration, the panel found that the DRA must have been a clarification of the pre-DRA statute without analyzing whether the DRA, in fact, effected a substantive change in the law. App. 8a-11a Finally, based on its findings that Petitioners could not reasonably have relied on the pre-DRA statute and that the DRA merely clarified the prior statute, the D.C. Circuit held that the DRA could be applied without concern for its retroactive effect. *Id.*

REASONS FOR GRANTING THE PETITION

This Court should grant certiorari to clearly delineate the circumstances, if any, in which a court may bypass the rigorous analysis that must be employed before the presumption against retroactive application of new legislation can be overcome. The decisions of the Courts of Appeals are in considerable conflict on this issue—and the D.C. Circuit now has joined several circuits in employing an approach that circumvents the required analysis, resulting in a weakening of a presumption "deeply rooted in our jurisprudence." *Landgraf*, 511 U.S. at 265.

This Court has long-held that "congressional enactments and administrative rules will not be construed to have retroactive effect unless their language requires this result." *Landgraf*, 511 U.S. at 264 (quoting *Bowen v. Georgetown University Hospital*, 488 U.S. 204, 208 (1988)). This presumption against retroactivity buttresses specific constitutional guarantees, including the right to due process of law, and reflects "[e]lementary considerations of fairness," which

"dictate" that "individuals have an opportunity to know what the law is and to conform their conduct accordingly." *Id.* at 265 (citations omitted). The presumption thus "accords with widely held intuitions about how statutes ordinarily operate" and "generally coincide[s] with legislative and public expectations" that a newly-enacted statute will only apply to post-enactment conduct. *Id.* at 272.

In accordance with this constitutionally-based presumption, this Court has made clear that only Congress can authorize the retroactive application of new legislation and likewise has held that Congress must make clear its intent when making that authorization. Thus, "the first step in [the retroactivity analysis] is to ascertain whether Congress has directed with requisite clarity that the law be applied retrospectively." *St. Cyr*, 533 U.S. at 316. Indeed, "[c]ases where this Court has found truly retroactive effect adequately authorized by statute have involved statutory language that was so clear that it could sustain only one interpretation." *Lindh v. Murphy*, 521 U.S. 320, 328 n.4 (1997). Requiring such clarity "assures that Congress itself has affirmatively considered the potential unfairness of retroactive application and determined that it is an acceptable price to pay for the countervailing benefits [and] allocates to Congress responsibility for fundamental policy judgments concerning the proper temporal reach of statutes ..." *Landgraf*, 511 U.S. at 272-73

Further, this Court also has made clear that, absent an unmistakable congressional directive for retroactive application, a new statute that

would have a "retroactive effect" can be applied on a prospective basis only. *St. Cyr*, 533 U.S. at 315-16 ("retroactive statutes raise special concerns," and therefore "a statute may not be applied retroactively ... absent a clear indication from Congress that it intended such a result."). A statute has an impermissible retroactive effect if it "attaches new legal consequences to events completed before its enactment." *St. Cyr*, 533 U.S. at 321 (citation and internal quotations omitted).

Here, however, the D.C. Circuit determined that the DRA could be applied retroactively even though Congress did not expressly authorize the statute's retroactive application and even though the DRA altered the legal consequences of acts completed before its effective date. The decision is a marked departure from this Court's precedents establishing high hurdles that must be cleared before the presumption against retroactivity can be overcome. The decision, moreover, directly implicates and heightens existing controversies in the circuits concerning two pivotal and outcome determinative issues relating to the retroactivity analysis.

First, the D.C. Circuit concluded that the presumption against retroactivity did not apply because the DRA was merely a "clarification," not a change in the law. This Court has not directly spoken to the question of where this clarification construct fits in the retroactivity analysis; and the circuits have taken different approaches when considering the issue. Since the "clarification" label has become a proxy to avoid any analysis of the overarching presumption against

retroactivity, there is a need for consistency in resolving whether or when a purported statutory "clarification" can circumvent *Landgraf's* retroactivity principles. Perhaps more importantly, since the circuits already are in disagreement on this issue, only this Court can supply the much-needed uniformity.

Second, the D.C. Circuit's view that the presumption against retroactivity is not implicated absent proven reliance on the pre-existing law also dangerously weakens the presumption and deepens the considerable conflict among the circuits over (1) the role reliance plays in the retroactivity analysis and (2) whether this Court's decision in *St. Cyr* altered the foundational retroactivity principles established in *Landgraf*. Here again, because the conflict has ripened, only this Court can settle the matter.

Nor is the need for this Court's intervention a matter of surmise or hypothesis. As shown more fully below, application of these various legal standards yields inconsistent results, with the constitutionally-grounded presumption intervening to prevent retroactive application in some circuits but not in others.

This case affords this Court the ideal opportunity to resolve the substantial disagreement among the circuits on whether and when the presumption against retroactivity can be overcome and thereby help to reduce or avoid the inconsistencies that presently exist. Guidance from this Court also will provide the added benefit "of giving legislators ... predictable background rule[s] against which to legislate."

Landgraf, 511 U.S. at 273. Review likewise is warranted to restore the efficacy of the principle embodied in a well-entrenched and pervasive presumption—that is, "the principle that the legal effect of conduct should ordinarily be assessed under the law that existed when the conduct took place[,] ... a rule of law that gives people confidence about the legal consequences of their actions." *St. Cyr*, 533 U.S. at 316 (citations omitted).

I. The Decision Below Conflicts With This Court's Precedents And Deepens A Recognized Conflict In The Circuits On Whether And When Statutory Amendments Can Be Characterized As A "Clarification" And Not Subject To The Presumption Against Retroactivity.

Despite the reasoning in this Court's precedents, the D.C. Circuit did not begin by asking the core threshold question in the retroactivity analysis, *i.e.*, whether Congress expressed a clear intent that the DRA be applied retroactively. The court only turned to the question of whether Congress intended the DRA to apply retroactively at the end of its opinion, perfunctorily concluding that because "it was unclear prior to the Deficit Reduction Act, whether the Secretary had discretion to exclude the expansion waiver population from the disproportionate share hospital adjustment[,] ... [i]t follows that there is no problem of retroactivity. The Deficit Reduction Act did not retroactively alter settled law; it simply clarified

an ambiguity in the existing legislation." App. 10a-11a.

This Court has not spoken directly to the question of how, if at all, the D.C. Circuit's clarification construct fits in the retroactivity analysis. In the absence of this Court's guidance, the circuits have taken different approaches to whether a conclusion that legislation is a "clarification" avoids *Landgraf's* retroactivity analysis and, if it does, what is required to establish that legislation is a clarification that can be applied retroactively without such analysis. *Levy v. Sterling Holding Co. LLC*, ___ F.3d ____, 2008 WL 4415135, at *12 (3d Cir. Oct. 1, 2008) (recognizing divergent views on whether a clarification raises retroactivity concerns requiring evaluation under the *Landgraf* analysis) (citing cases including the D.C. Circuit's opinion below).

Some circuits begin their analysis by assuming that if new legislation is a clarification of existing law, the presumption against retroactivity is not implicated and the new law can be applied to any controversy without a full analysis under *Landgraf* or its progeny. *See Porter v. Commissioner*, 856 F.2d 1205, 1209-10 (8th Cir. 1988); *ABKCO Music, Inc. v. LaVere*, 217 F.3d 684, 689 (9th Cir. 2000); *Barnes v. Cohen*, 749 F.2d 1009, 1015-16 (3d Cir. 1984); *Brown v. Thompson*, 374 F.3d 253, 259 (4th Cir. 2004); *Beverly Community Hospital Association v. Belshe*, 132 F.3d 1259, 1264 (9th Cir. 1997); *Piamba Cortes v. American Airlines, Inc.*, 177 F.3d 1272, 1283-84 (11th Cir. 1999); *see also Levy*, 2008 WL 4415135, at *12 (addressing agency

retroactive rule-making and explaining that a law does not implicate retroactivity concerns "if it 'd[oes] not alter existing rights or obligations [but] merely clarifie[s] what those existing rights and obligations ha[ve] always been'") (alterations in original) (quoting *Appalachian States Low-Level Radioactive Waste Commission v. O'Leary*, 93 F.3d 103, 113 (3d Cir. 1996)).

That view is not, however, universally accepted. For example, the Federal Circuit has explained that "[m]erely categorizing rules or applications of rules as 'clarifications' or 'changes' provides little insight into whether a retroactive effect would result in a particular case[,]" as "a clarification, in fact, 'changes the legal land scape,' because 'a precise interpretation is not the same as a range of possible interpretations.'" *Princess Cruises, Inc. v. United States*, 397 F.3d 1358, 1363 (Fed. Cir. 2005) (quoting *Health Insurance Association of America, Inc. v. Shalala*, 23 F.3d 412, 423-24 (D.C. Cir. 1994)). For this reason, the Federal Circuit concluded that "the binary analysis—change or clarification"—which short-circuits the *Landgraf* analysis—"conflicts with the court's obligation to weigh the various factors described in *Landgraf*[,] [as] *Landgraf* explicitly requires the court to consider 'the *nature and extent* of the change in the law,' not merely whether a change has occurred." *Princess Cruises*, 397 F.3d at 1363 (emphasis in original) (quoting *Landgraf*, 511 U.S. at 270).

Other circuit decisions express similar concerns over attempts to divine what is a mere "clarification," as opposed to a substantive change in the law. As Judge Posner observed, "Congress

is not an interpretive body .... 'The views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one.'" *Paramount Health Systems, Inc. v. Wright*, 138 F.3d 706, 710 (7th Cir. 1998) (quoting *United States v. Philadelphia National Bank*, 374 U.S. 321, 348-49 (1963) and citing *South Dakota v. Yankton Sioux Tribe*, 522 U.S. 329, 354-55 (1998)). More fundamentally, authorizing circumvention of *Landgraf's* more robust analysis by characterizing a statutory amendment as a mere "clarification" can lead to mischief or manipulation: "a disappointed litigant in a statutory case in a federal district court could scurry to Congress while the case was on appeal and request a 'clarifying' amendment that would reverse the interpretation that the district judge had given to the statute, even if that meaning was crystal clear ..." *Paramount Health*, 138 F.3d at 710.[3]

Beyond this threshold disagreement on whether a clarification can be relied on to bypass *Landgraf's* retroactivity analysis, the circuits likewise are not in agreement on the approach that should be applied in determining whether

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[3] Judge Posner took this concern a step further when he also observed that applying a "clarification" retroactively in the absence of a clear congressional statement expressly authorizing retroactive application collides with the "principle that Congress cannot direct the outcome of a pending case without changing the law applicable to that case." *Paramount Health*, 138 F.3d at 710 (citing *Plaut v. Spendthrift Farm, Inc.*, 514 U.S. 211, 218 (1995)) (other citations omitted).

Congress has clarified rather than changed the law.

The Eighth Circuit, for instance, has concluded that new legislation amounts to a clarification, rather than a change in the law, where the record "unmistakabl[y]" demonstrated that "Congress intended to take dead aim at a case that runs afoul of Congress' original intent" by "identif[ying] the objectionable holding ... and indicat[ing] [its] intention to overturn that holding." *Porter*, 856 F.2d at 1210; *see also id.* at 1209 (noting a House Conference report expressly stating that a recent court decision was incorrect and that "[u]nder the House bill, the decision is overturned ..."). The Ninth Circuit has employed this approach as well. *See ABKCO Music*, 217 F.3d at 690-91 (observing that the Conference Committee stated that the amendment "restores the law to what it was before [a] decision of the Ninth Circuit ... and reverses [the Ninth Circuit's] decision ...") (quoting H.R. Rep. No. 105-325 at 5 (1995)).

Still other circuit decisions have held that new legislation can be characterized as a clarification where Congress finds a split in judicial authority and clearly expresses its intent to resolve that controversy. The Third Circuit thus found that statements made by the Chairman of the Conference Committee and another member of Congress "explicitly stat[ing] that the purpose of the amendment ... was to clarify the original statute in light of conflicting court decisions" "tip[ped] the scales in favor of finding the amendment to be a 'clarification' rather than a 'change.'" *Barnes*, 749 F.2d at

1015-16. Likewise, the Fourth Circuit found that an amendment was a clarification when Congress acted where "courts were divided[,]" noting Senator Grassley's express statement that the amendments "do not change existing law ... but, in fact, clarify the intent of Congress ...." *Brown*, 374 F.3d at 257-60 (quoting 149 Cong. Rec. S15584-85 (daily ed. Nov. 22, 2003)). The Ninth Circuit similarly concluded that Congress had clarified existing law where it indicated that it was "deliberately targeting what were known to be existing disputes on the subject." *Beverly*, 132 F.3d at 1266.

Attempts to reconcile these differing approaches are difficult, if not futile. While each of these decisions involves a threshold inquiry aimed at determining whether Congress has acted to "overrule" a judicial decision or address a split in judicial authority, there nonetheless is disagreement on how explicit Congress must be in indicating that legislation is a clarification of existing law. On one end of the spectrum, courts have found legislation to be a clarification, not just because Congress took direct aim at a judicial decision or circuit split, but also because Congress expressly authorized some type of "retroactive application" in the text of statute itself. *See Beverly*, 132 F.3d at 1264 (noting that "effective date" provision of statute directed that "[t]he amendments ... shall also apply to payments by a State for items and services furnished before [the effective date] if such payment is the subject of a lawsuit that is based on [the prior law]"); *Brown*, 374 F.3d at 259 (explaining that Congress "expressly provided in [the statute] that these

technical and clarifying amendments be made effective 'as if included in the enactment' of the [earlier] legislation preceding the 1989 amendments"). At the other end of the spectrum, decisions have suggested that the existence of a controversy in the courts might be sufficient to find that Congress had clarified rather than changed the law even in the absence of any express indication that Congress acted specifically to resolve the controversy in the courts. *See Brown*, 374 F.3d at 259 n.2 ("[E]ven if Congress had given no direct indication that it intended [the new legislation] to be clarifying, courts regularly view a conflict in the courts with regard to the proper interpretation of a statute—as existed [here]—as an indication that Congress passed a subsequent amendment to clarify rather than change existing law"); *Piamba Cortes*, 177 F.3d at 1283-84 (holding that a significant factor in determining whether an amendment clarifies or substantively changes the law is whether a substantial split in authority exists).

The differences in the circuits' approaches, moreover, are consequential. They can and do lead to different results on the retroactivity question even when the same statute is involved. This case illustrates the profound incongruities resulting from the divergent approaches.

Here, for example, the D.C. Circuit weighed in on the side of the circuits "finding retroactivity to be a non-issue with respect to new laws that clarify existing law." *Levy*, 2008 WL 4415135, at *12 (citing D.C. Circuit's opinion together with *Barnes*, *Piamba Cortes* and other cases). Yet, if this case had been decided in the Federal Circuit,

Landgraf's much more rigorous analysis would have been employed—leading to a finding that the DRA could not be applied retroactively because there is no express indication of an intent to clarify existing law, much less for the retroactive application in the first instance.[4]

The divergence, however, does not end with these two circuits. The outcome would have been different even in those circuits sharing the D.C. Circuit's view that clarifying amendments fall outside *Landgraf's* presumption. In contrast to the analysis employed in several other circuits, the D.C. Circuit did not focus on whether the text of the DRA or its legislative history indicated that Congress intended §5002 to be a clarification of what Congress intended all along in the Medicare

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[4] Section 5002 of the DRA includes no express retroactivity provision and the language of §5002(a), which allows the Secretary to exclude expansion waiver days from the DSH calculation, looks only to the present and the future, providing that the Secretary "may ... include" certain inpatient days in the DSH calculation. Since there is no indication that Congress was acting retroactively when it enacted the DRA, it is much more plausible that it was concerned about prospectively reducing the cost of the Medicare and Medicaid programs. *See Paramount Health System*, 138 F.3d at 710 ("The location of the 1997 amendments in a statute labeled the 'Balanced Budget Act' and concerned primarily with cutting the federal deficit hardly creates confidence that Congress was, court-like, interpreting the 1986 statute. It is far more realistic to regard the ... provisions as designed to change the original statute in order to reduce the cost of Medicaid to the federal government. Nothing in the provisions themselves suggests a process of interpretation; they merely declare that the states are not required to reimburse [qualified Medicare beneficiary] providers at the Medicare rate.").

statute. The Fourth and Ninth Circuits, by comparison, would have searched the text of the DRA for an indication of intent for retroactive application and would have reached a different conclusion on whether the DRA could be applied retroactively because nothing in the language of the DRA suggests that Congress authorized retroactive application of the new legislation.

Still other circuits, as noted, would have looked for clear indications that Congress was targeting a judicial decision not in accord with the intent of the pre-DRA Medicare statute or judicial decisions interpreting the statute in different ways. This analysis would have yielded a different outcome here as well. Nothing in the text of the DRA or other legislative materials indicates that Congress was responding to either a judicial decision it believed had incorrectly construed the Medicare statute or divergent judicial interpretations of the statute. In fact, there was no such controversy. Prior to the DRA's enactment, every court that had considered the issue had ruled that the pre-DRA Medicare statute unambiguously required expansion waiver days to be included in the DSH calculation.[5]

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[5] Congressional statements would indicate that Congress did not disagree with those decisions. In 1997, when directing the Secretary to provide a report on certain information relating to the Medicare DSH calculation, Congress expressly stated that pre-DRA Medicare DSH calculation includes not only traditional Medicaid days, but also "individuals who receive medical assistance under [Title XIX] pursuant to a waiver approved by the Secretary under section 1115 ...." *See* Pub.L.No. 105-33, §4403(b)(3)(B).

Consequently, although it joined the ranks of those circuits holding that clarifications do not raise retroactivity concerns, the D.C. Circuit adopted yet another distinct approach to assessing whether a statute is merely a clarification of existing law and thereby serves to avoid *Landgraf's* retroactivity analysis. The court concluded that the DRA must have been a clarification because, in the court's own view, the pre-DRA statute was ambiguous. The unstated premise underlying this approach—that whenever Congress amends what a court believes to be an ambiguous statute then Congress must be "clarifying" the law—creates further opportunities for mischief in this already unsettled area of law.

Of course, Congress might amend an ambiguous statute because it wants to clarify it. But it also could take that step because it wants to change the law—and a court's own views on statutory ambiguity perforce say nothing about *Congress' intent* in enacting the new legislation.[6]

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[6] Here, for example, even Congress's use of the word "clarification" in the title of §5002 does not necessarily resolve the question of whether the DRA constitutes a change in the law. *See St. Cyr*, 553 U.S. at 208-09 ("[A] title alone is not controlling.") (citing *Pennsylvania Department of Corrections v. Yeskey*, 524 U.S. 206, 202 (1998) ("[T]he title of a statute ... cannot limit the plain meaning of the text."); *United States v. Marmolejos*, 140 F.3d 488, 492-93 (3d Cir. 1998) ("[T]he mere fact that an amendment is referred to as a clarification or a revision is ordinarily of slight import to [the] analysis."); *Cruz v. American Airlines, Inc.*, 193 F.3d 526, 530 (D.C. Cir. 1999) (Statutory "[p]rovisions [that] clearly amend prior law ... cannot possibly be given retroactive effect by being labeled a

See Brown, 374 F.3d at 259 ("In determining whether an amendment clarifies or changes an existing law, a court, of course, looks to statements of intent made by the legislature that enacted the amendment."). Therefore, a proper analysis of whether the DRA was a clarification should have started with an examination of congressional intent in enacting the pre-DRA statute, without reference to subsequent enactments or agency statements on the prior law. *See Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 342-43 (1984) ("If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress ...."). But the D.C. Circuit bypassed that analysis and determined that the pre-DRA statute was "unclear" by relying on its own view of the import of enacting the DRA and of agency statements regarding the pre-DRA statute. App. 10a-11a (evaluating whether the pre-DRA statute was "unclear" by asking which reading of that statute "finds some support in the [DRA]"). Here again, however, an analysis of the pre-DRA statute under settled rules of statutory construction would have yielded a different result—*i.e.*, that the statute was unambiguous and there was no need to look elsewhere to ascertain the intent of Congress. That, in turn, would have revealed that Congress had *changed* the law in enacting the DRA.

'clarification.'"). In fact, as the district court in *Cookeville II* concluded, "what [Congress] called a "clarification" was actually a substantive change in the law. App. 25a-26a.

The D.C. Circuit added another novel twist by concluding that, through the DRA's very limited ratification provision, Congress was "emphasiz[ing] that the Secretary always had [the] discretionary authority [to exclude expansion waiver days from the DSH calculation]." App. 10a-11a (citing DRA §5002(b)).[7] That ratification provision does not provide a basis to find that the DRA was merely a clarification of the pre-DRA Medicare statute, as it too says nothing about what *Congress meant* in that earlier legislation.[8] What's more, although "ratification" can be used to cure defects in agency authority, it cannot be relied upon to authorize retroactive application of new legislation that changes the law unless Congress states that it is changing the law to comport with the agency's construction of the statute (which was at odds with prior law) *and* expressly states that it intends the legislation to apply retroactively. *See EEOC v. CBS, Inc.*, 743 F.2d 969, 974 (2d Cir. 1984) ("ratifying legislation must recognize that the actions involved were unauthorized when taken and must also expressly ratify those actions

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[7] The limited ratification provision in §5002(b) contains a January 20, 2000 effective date, which means that, by its express terms, it does not cover the patient discharges at issue in this case, all of which predate January 20, 2000. *See* DRA §5002(b)(1).

[8] Any approach that relies on the ratification construct to circumvent the required retroactivity analysis also would conflict with the settled rule that an agency has no retroactive rule-making power unless given that power by Congress, and, even then, its "rules will not be construed to have retroactive effect unless their language requires this result." *Bowen*, 488 U.S. at 208.

in clear and unequivocal language"). Indeed, interpreting §5002(b) as effectuating a retroactive change in the law violates the prohibition against using ratification to retroactively create new legislative policy. *See Swayne & Hoyt v. United States*, 300 U.S. 297, 300-02 (1937) ("distinction must be taken between a bare attempt of the Legislature retroactively to create liabilities for transactions ... fully consummated in the past ... and the case of a curative statute aptly designed to remedy mistakes and defects in the administration of government ....").

In the end, the D.C. Circuit's approach to the clarification issue is a deeply troubling variation on an equally troubling theme. This Court's precedents emphasize that only Congress can say that new legislation should be applied retroactively. Yet, under the D.C. Circuit's approach, a court's own conclusion that new legislation is a clarification, untethered to a searching analysis of Congress's intent to clarify, becomes a means to avoid the constitutionally-grounded presumption against retroactivity. *See St. Cyr*, 533 U.S. at 320 n.45 ("a statute that is ambiguous with respect to retroactive application is construed under our precedents to be unambiguously prospective") (citing *Landgraf*, 511 U.S. at 264). Even if a finding that a statute is a clarification can be sufficient reason to end the retroactivity analysis, the question should remain whether *Congress intended* the amendment to be a clarification—and one that should be applied retroactively at that. *Landgraf*, 511 U.S. at 272-73 ("Requiring clear intent assures that Congress itself has affirmatively

considered the potential unfairness of retroactive application ...and has the additional virtue of giving legislators a predictable background rule against which to legislate.").

This Court's guidance thus is needed to settle the law on whether and when a purported "legislative clarification" of existing law can be applied retroactively. Without that guidance, the constitutional principles embodied in the presumption against retroactivity will continue to be applied inconsistently, with disparate and irreconcilable results.

II. The Decision Below Conflicts With This Court's Precedents And Deepens Recognized Conflict In The Circuits On The Role Reliance Plays In The Retroactivity Analysis.

Because Congress did not expressly authorize retroactive application of the DRA, prospective application of the statute is required unless it lacks a retroactive effect. *Landgraf*, 511 U.S. at 280. The D.C. Circuit, however, short-circuited the assessment of whether application of the DRA to Petitioners' claims would have an impermissible retroactive effect. The court held that the DRA could be applied retroactively because the Hospitals could not reasonably have relied on the pre-DRA Medicare statute as a result of the Secretary's and certain fiscal intermediaries' position that expansion waiver days should not be included in the Medicare DSH calculation. App. 7a-8a. Under the D.C. Circuit's reasoning, therefore, the presumption against retroactivity cannot be invoked in the absence of

actual subjective reliance by the party resisting retroactive application.

In adopting that approach, the D.C. Circuit's holding once again deepens an existing circuit split. As with the "clarification" question, the split among the circuits goes beyond mere academic concern. The outcome of a retroactivity analysis involving the same federal statute and same set of circumstances varies greatly from circuit to circuit and with those variations comes different declarations of what due process purportedly requires.

First, there is an avowed conflict over whether reliance on prior law is a prerequisite for application of the presumption against retroactivity—a conflict expressly acknowledged by the lower courts. *See Martinez v. INS*, 523 F.3d 365, 384 (2d Cir. 2008) (Straub, J., concurring) (noting disagreement on whether "reliance should be a requirement at all"); *Hernandez de Anderson v United States*, 497 F.3d 927, 938 (9th Cir. 2007) (noting "considerable disagreement among the courts of appeal considering whether 'reasonable reliance' ... is a required element of a *Landgraf* claim"); *Hem v. Maurer*, 458 F.3d 1185, 1191 (10th Cir. 2006) ("lower courts have split over ... whether reliance must be established objectively, subjectively, or even at all"); *United States v. De Horta Garcia*, 519 F.3d 658, 666 (7th Cir. 2008) (Rovner, J., concurring) (noting disagreement among circuits and concluding that, although Seventh Circuit precedent requires proof of reliance, "[p]ersuasive authority from our sister circuits suggests ... that

... the precedents ... may be incorrect and should be revisited").

The Third, Fourth and Tenth Circuits have held that reliance is not a prerequisite for invocation of the presumption against retroactivity—and, indeed, that any such requirement would be inconsistent with this Court's precedents.[9] The D.C. Circuit now joins the First, Second, Fifth, Seventh and Ninth Circuits in holding that that, unless reliance on the prior law is established, there is no prohibition against applying a new statute retroactively.[10]

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[9] *Atkinson v. United States*, 479 F.3d 222, 227-28, (3d Cir. 2007) ("[t]he Court has never held that reliance on the prior law is an element required to make the determination that a statute may not be applied retroactively"); *Hernandez v. Gonzales*, 437 F.3d 341 (3d Cir. 2006) ("In sum, '[t]he *Landgraf* line ... establishes that a change in law can be found impermissibly retroactive without establishing that some (or all) members of the group affected by the change in law relied on the prior state of the law.'") (quoting *Ponnapula v. Ashcroft*, 373 F.3d 480, 490 (3d Cir. 2004); *Olatunji v. Ashcroft*, 387 F.3d 383, 391 (4th Cir. 2004) ("[T]he consideration of reliance is irrelevant to statutory retroactivity analysis"); *Hem*, 458 F.3d at 1198-99 ("Consistent with ... the *Landgraf* cases, [the Supreme] Court never converts 'detrimental reliance' on prior law into a prerequisite for sustaining a retroactivity claim. Rather, the retroactivity inquiry remains the two part inquiry established in *Landgraf*, together with a strong presumption against retroactive application, with no discussion of reliance even appearing until the Court summarizes the pertinent facts of *St. Cyr*.") (citation omitted).

[10] *Martinez*, 523 F.3d at 379 (Straub, J., concurring) (explaining that, in the Second Circuit, if reliance is not

Second, there is considerable disagreement in the circuits over what type of reliance—objectively reasonable reliance or individualized subjective reliance—must be established in undertaking the retroactivity analysis. *Hernandez de Anderson*, 497 F.3d at 938 (noting "considerable disagreement among the courts of appeal considering whether ... if some form of reliance is required, what form it must take"); *Martinez*, 523 F.3d at 382 (Straub, J., concurring) (noting that whether "petitioners arguing impermissible retroactivity show individualized, detrimental reliance on the prior law is the subject of a considerable amount of controversy among, within, and surrounding the courts of appeals and may be ripe for re-examination or review").

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shown there is no need to "examine 'whether the new provision attaches new legal consequences to events completed before the enactment,' *Landgraf*, 511 U.S. at 269-70," and that "in order to successfully argue that the rule is impermissible retroactive as applied to [the] case, [party] must show that he detrimentally relied on the prior rule"); *De Horta Garcia*, 519 F.3d at 666 (Rovner, J., concurring) (explaining that Seventh Circuit requires proof of reliance); *Camins v. Gonzales*, 500 F.3d 872, 884 (9th Cir. 2007) ("We have formulated this rule in the negative: Aliens making a *Landgraf* retroactivity argument cannot prevail if they cannot plausibly claim that they would have acted ... differently if they had known about the elimination of [the] relief.") (quoting *Hernandez de Anderson*, 497 F.3d at 939; *Dias v. INS*, 311 F.3d 456, 458 (1st Cir. 2002) (absent proof of reliance, "[one] may not argue that the statute has impermissible retroactive effect as to him."); *Carranza-de Salinas v. Gonzales*, 477 F.3d 200, 206 (5th Cir. 2005) ("[T]his circuit requires [one] ... to demonstrate actual, subjective reliance on the [prior] state of the law to be eligible for relief from its retroactive application.").

The circuits again are closely divided on this issue. Five circuits—counting the D.C. Circuit—require proof of actual subjective reliance by the party resisting retroactive application.[11] Five circuits have held that when reliance is involved—either as a prerequisite for application of the presumption against retroactivity or as a factor sufficient to conclude that the presumption is not overcome—reliance need be only objectively reasonable.[12]

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[11] *Groccia v. Reno*, 234 F.3d 758, 763 (1st Cir. 2003) (requiring a showing of "actual and reasonable reliance"); *Martinez*, 523 F.3d at 379 (2d Cir.) (Straub, J., concurring) ("[I]n [the Second] Circuit, petitioners seeking to show that the new law was impermissibly applied to their case retroactively must show that they detrimentally relied on the prior law."); *Carranza-de Salinas*, 477 F.3d at 206 ("[The Fifth] circuit requires ... actual, subjective reliance"); *De Horta Garcia*, 519 F.3d at 661 ("[The Seventh Circuit] require[s] a showing of specific facts demonstrating actual reliance."); *but see De Horta Garcia*, 519 F.3d at 665 (Rovner, J., concurring) ("[N]o Supreme Court decision requires or turns on proof that the party contesting retroactive application of new legislation actually relied to his detriment on prior law in setting his own course of conduct ... To the extent that reliance ought to play a role in the retroactivity analysis, it is objective rather than subjective reliance that should be considered[.]").

[12] Although the Ninth Circuit has held that reliance is required, it has concluded that only objectively reasonable reliance must be shown. *Camins*, 500 F.3d at 884 ("[W]e require that reliance on the prior law would have been objectively reasonable under the party's circumstances"). The Third, Fourth and Tenth Circuits do not require reliance, but have held that when reliance is considered as a factor showing impermissible retroactive effect, that reliance need be only objectively reasonable. *Ponnapula*, 373 F.3d at 493 ("The likelihood that the party before the

Third, this Court's later decision in *St. Cyr* has produced another level of disagreement among the circuits on the role reliance plays in the retroactivity analysis. *See, e.g., Hernandez de Anderson*, 497 F.3d at 938 ("*St. Cyr* has produced considerable disagreement among the courts of appeal considering whether "reasonable reliance" ... is a required element of a *Landgraf* claim to that relief, and, if some form of reliance is required, what form it must take") (cataloging circuit split); *Hem*, 458 F.3d at 1191 ("Since *St. Cyr*, lower courts have split over ... whether reliance must be established objectively, subjectively, or even at all").

Several circuits have concluded that *St. Cyr* fundamentally altered the retroactivity analysis such that the presumption against retroactivity does not apply unless there was reliance on prior law.[13] *See, e.g., Martinez*, 523 F.3d at 379-80

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court did or did not in fact rely on the prior state of the law is not germane to the question of retroactivity. Rather, courts are to concentrate on the group to whose conduct the statute is addressed ...."); *Olatunji*, 387 F.3d at 396; *Hem*, 458 F.3d at 1187, 1195 ("*St. Cyr* leaves little doubt that the Supreme Court has never insisted upon actual reliance ... and "[w]e conclude that an objective showing of reliance is the appropriate rule."). The Sixth Circuit has not clearly weighed in on the question of whether reliance is a prerequisite, but have held that when reliance is involved, it need be only be objectively reasonable. *Thaqi v. Jenifer*, 377 F.3d 500, 504 n.2 (6th Cir. 2004) ("The petitioner need not demonstrate actual reliance ... in order to demonstrate an impermissible retroactive effect").

[13] Although these post-*St. Cyr* decisions arose in the immigration context, the circuit's conclusions on reliance are stated as general propositions that would be applicable whenever the retroactivity question arises.

(Straub, J., concurring) (explaining that Second Circuit's view that reliance is a requirement resulted from *St. Cyr* (citations and internal quotations omitted); *Atkinson*, 479 F.3d at 227 (noting that "since the Court's decision in *St. Cyr*, courts of appeals in other circuits have understood the Court's discussion of reliance and quid pro quo as requiring that there be reliance on the prior state of the law") (citations omitted).

The Third and Fourth Circuits, however, disagree that *St. Cyr* altered the foundational retroactivity analysis. As the Third Circuit explained, "reading ... *St. Cyr* [as requiring reliance] runs contrary to our understanding of prior Supreme Court law ... *Landgraf* teaches that, in determining if a statute applies retroactively, a court must begin with the statute. If the statute is ambiguous as to its temporal reach, the question is whether it attaches new legal consequences to past events. If the court determines that the statute has retroactive effect because of such consequences, that determination is applied across the board." *Atkinson*, 479 F.3d at 227 (citations omitted). The Third Circuit further observed that, in *St. Cyr*, this Court did not "consider whether, beyond the reliance factor, there were other indicia that [the statute] attached new legal consequences to completed events," *Atkinson*, 479 F.3d at 227, because it did not need to, as "[the] Court regarded *St. Cyr* as a clear and straightforward result flowing from *Landgraf* .... *St. Cyr* was an easy case on the retroactivity issue." *Ponnapula*, 373 F.3d at 492-93. Likewise, the Fourth Circuit has concluded that "*St. Cyr* did not alter the requirements for

establishing retroactivity [and] did not purport to add a subjective reliance requirement; rather, it applied *Landgraf* to a set of facts [where petitioner's reliance] indicated 'an *obvious and severe* retroactive effect.'" *Olatunji*, 387 F.3d at 393 (quoting *St. Cyr*, 533 U.S. at 325).

By concluding that reliance is a prerequisite for invocation of the presumption against retroactivity, the D.C. Circuit and several others have fundamentally altered the retroactivity analysis. In those circuits, the retroactivity determination does not turn on whether the new statute has an impermissible effect—by, say, "attaching a new legal consequence to events [already] completed]" or "tak[ing] away or impair[ing] vested rights acquired under existing law"[14]—but instead turns only on whether there was reliance on the prior law. What's more, most of these circuits have erected an even higher hurdle for application of the presumption against retroactivity by requiring proof of actual subjective reliance.

This Court has never held that the presumption against retroactivity applies only if reliance—much less the individualized subjective reliance required by some circuits—is established.[15] Instead, this Court's retroactivity

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[14] *St. Cyr*, 511 U.S. at 321; *Landgraf*, 511 U.S. at 269 n.23.

[15] *See Atkinson*, 479 F.3d at 229 (In *Hughes*, "there is no consideration ... of whether Hughes Aircraft, in particular, or any defendant, in general, in an FCA action might have relied on the former law in conducting business with the government. [Rather,] it was the new legal burden imposed on events past, rather than reliance on the former law by the person affected, which was the basis for holding that

jurisprudence provides illustrations of the types of statutes that have impermissible retroactive effect—*e.g.*. a law that "attaches new legal consequences to events completed before its enactment[,]" *Cyr*, 533 U.S. at 321, or "takes away or impairs vested rights acquired under existing laws, or creates a new obligation, imposes a new duty, or attaches a new disability, in respect to transactions or considerations already past ...." *Landgraf*, 511 U.S. at 269 n.3; *see Hughes*, 520 U.S. 947 ("[T]he Court has used various formulations to describe the 'functional conceptio[n] of legislative "retroactivity,"' and made no suggestion that [this] formulation was the exclusive definition of presumptively impermissible retroactive legislation.") (quoting *Landgraf*, 511 U.S. at 269). None of the illustrations of impermissible retroactive effects provided in this Court's precedents "purport to define the outer limit on impermissible retroactivity[,] [but] rather merely described that any such effect constitute a *sufficient*, rather than a *necessary*, condition for invoking the presumption against retroactivity." *Hughes*, 520 U.S. at 947 (emphasis in original).

As a result, elevation of reliance to a requirement effects a sea change in retroactivity jurisprudence and, like the approach to "clarification," significantly limits the circumstances in which the deeply-rooted presumption against retroactivity can be invoked.

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the ... amendment would not be applied retroactively"); *see also Olatunji*, 387 F.3d at 391 ("That the Supreme Court in *Landgraf* did not intend to impose a requirement of reliance is confirmed by *Hughes Aircraft*.").

These circuits effectively approach the retroactivity analysis as if there is a presumption in *favor* of retroactive application, which must be rebutted before any prospective application will take hold. But any rule that "[has] the effect of treating *Landgraf* as establishing a presumption in favor of retroactive application" would be in "considerable tension with the presumption against retroactivity" and "would be wrong, as the Supreme Court has held explicitly that a federal court of appeals erred by concluding that *Landgraf* contained a 'strong presumption *in favor of retroactivity*.'" *Hernandez*, 437 F.3d at 349 (quoting *Hughes*, 520 U.S. at 950) (emphasis in original).[16]

In this case, Petitioners provided treatment to expansion waiver populations pursuant to a Medicare statute that unambiguously provided that expansion waiver days should be counted in the DSH adjustment. Without looking at what

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[16] The D.C. Circuit did not evaluate Petitioners' expectations through the lens of the pre-DRA Medicare statute. Instead, its reliance analysis begins and ends with a focus on administrative statements on the pre-DRA Medicare statute—without ever concluding that these statements in fact correctly reflected what Congress intended. Under this reasoning, therefore, whenever an agency announces loudly or often a view contrary to a statute that is ultimately amended, there will be advance notice that the prior law could not be relied upon. App. 7a-8a. In this way, elevating reliance to the essential prerequisite for application of the presumption will allow an administrative agency to dictate the outcome of the retroactivity analysis. That approach is contrary to a foundation of retroactivity analysis—"shared expectations about the usual operation of legislation." *Landgraf*, 511 U.S. at 272-273, 286.

Congress intended by the passage of the DRA, the D.C. Circuit used a purported lack of reliance on the pre-DRA statutory scheme to cut-off Petitioners' right to reimbursement. And it did so even though there is no express congressional intent for the DRA's retroactive application and even though the DRA's retroactive application changes the legal consequences of acts completed before its effective date. Had Petitioners' appeal been resolved in one of the circuits that takes a more robust approach to retroactivity analysis, the outcome would have been different and Petitioners would have been entitled to more than $54 million in DSH payments plus interest.

In the face of such inconsistencies, there once again is a need for guidance on this aspect of the retroactivity analysis as well. If this Court intended for the reliance inquiry to trump the *considerations* it identified in *Landgraf* to reinforce the constitutionally-based presumption against retroactivity then it should say so to bring the circuits that apply a more rigorous analysis in line. If it did not, then it should grant this petition to avoid the injustice that occurred in this case and that will occur in many other contexts where a less searching retroactivity analysis is employed.

CONCLUSION

There are multiple levels of demonstrable conflicts in the circuits' approaches to dealing with the presumption against retroactivity. This case provides a means to lay the most significant of those conflicts to rest. The constitutionally-based retroactivity analysis should not produce differing outcomes in the same circumstances from circuit to circuit. Yet, that is the current state of the law. This Court's intervention is needed and respectfully urged.

Respectfully submitted.

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United States Court of Appeals,
District of Columbia Circuit.

COOKEVILLE REGIONAL MEDICAL CENTER, et al., Appellants,

v.

Michael O. LEAVITT, Secretary of the United States Department of Health and Human Services, Appellee.

Baptist Memorial Hospital, Inc., et al., Appellants

v.

Michael O. Leavitt, Secretary, United States Department of Health and Human Services, Appellee.

Nos. 07-5252, 07-5269.

Argued May 12, 2008.
Decided June 27, 2008.

Appeal from the United States District Court for the District of Columbia (Nos. 04cv01053, 06cv00437).

Murray J. Klein argued the cause and filed the briefs for appellants Cookeville Regional Medical Center, et al.

Sanford E. Pitler argued the cause for appellants Baptist Memorial Hospital, Inc., et al. With him on the briefs were Carol Sue Janes, Julie Quagliano Westemeier, and Michael C. Zisa.

August E. Flentje, Attorney, U.S. Department of Justice, argued the cause for appellee. With him on the brief were Jeffrey S. Bucholtz, Acting Assistant Attorney General, Jeffrey A. Taylor, U.S. Attorney, and Anthony J. Steinmeyer, Assistant Director.

Before: HENDERSON, RANDOLPH and ROGERS, Circuit Judges.

Opinion for the Court filed by Circuit Judge RANDOLPH.

RANDOLPH, Circuit Judge:

These appeals from judgments of the district court raise common issues regarding application of the Deficit Reduction Act of 2005, Pub.L. 109-171 (2006). The cases were brought by two groups of Tennessee hospitals serving patients who participate in the state's Medicaid plan, TennCare. A Medicaid plan provides medical assistance to qualifying low-income individuals. 42 C.F.R. § 430.0; 42 U.S.C. § 1396h *et seq.* The federal government shares the cost of providing assistance if the state Medicaid plan meets the regulations set out in subchapter XIX of the Social Security Act. *See* 42 U.S.C. § 1396a.

TennCare is a non-standard Medicaid plan known as a demonstration project. A demonstration project is a plan for which some of the regulations imposed on Medicaid plans under subchapter XIX are waived in order to "enable the states to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of recipients." 42 C.F.R. § 430.25; *see also* 42 U.S.C. § 1315. Despite not meeting the requirements of subchapter XIX, the costs of providing care under a demonstration project are treated as federally reimbursable expenditures made under subchapter XIX "to the extent and for the period prescribed by the Secretary [of Health and Human Services]."[1] 42 U.S.C. § 1315(a)(2)(A).

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[1] "In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to

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TennCare provides medical assistance to Medicaid-eligible low-income individuals and select uninsured or uninsurable individuals who would not otherwise qualify for Medicaid.[2] This latter group of individuals who receive federally reimbursable care under TennCare despite not meeting the normal Medicaid requirements is known as the "expansion waiver population."[3]

The central issue in these cases is whether the expansion waiver population should be counted in determining a hospital's Medicaid reimbursement. At the end of each year, hospitals prepare cost

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Continued from previous page

assist in promoting the objectives of subchapter I, X, XVI, or XIX of this chapter, or part A or D of subchapter IV of this chapter, in a State or States –

> costs of such project which would not otherwise be included as expenditures under section 303, 655, 1203, 1353, 1383, or 1396b of this title, as the case may be, and which are not included as part of the costs of projects under section 1310 of this title, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such subchapter, or for administration of such State plan or plans, as may be appropriate." 42 U.S.C. § 1315(a)(2)(A).

[2] *See* Bureau of TennCare, *Overview*, available at http:// www. state. tn. us/ tenncare/ news- about. html (visited May 13, 2008).

[3] *See also Medicare Inpatient Disproportionate Share Hospital Adjustment Calculation: Change in the Treatment of Certain Medicaid Days in States with 1115 Expansion Waivers*, 65 Fed.Reg. 3136, 3136 (Jan. 20, 2000) (noting that demonstration projects can expand coverage to otherwise Medicaid ineligible individuals).

reports seeking reimbursement for the treatment of Medicaid patients. 42 C.F.R. § 413.24(f). The cost reports are submitted to financial intermediaries, who report in a "notice of amount of program reimbursement" how much each hospital is owed from a state's Medicaid plan. 42 C.F.R. § 405.1803. The bulk of the reimbursement stems from the prospective payment system, under which a flat fee is paid for each day spent treating a Medicaid patient, based on the diagnosis or category of service provided. 42 U.S.C. § 1395ww; *see also* Fed. Trade Comm'n, *Improving Health Care: A Dose of Competition*, 31 J. HEALTH POL. POL'Y & L.. 437, 447 (2006). A hospital can supplement its reimbursement if it is eligible for one of several adjustments. One available adjustment is the disproportionate share hospital adjustment, which is given to hospitals serving a high percentage of low-income patients.

A statutory formula determines whether the percentage of low-income patients a hospital treats qualifies it for a disproportionate share hospital adjustment and how much that adjustment should be. *See* 42 U.S.C. § 1395ww(d)(5)(F)(v). The disproportionate share percentage consists of the sum of two fractions. *Id.* § 1395ww(d)(5)(F)(vi). The second fraction-known as the Medicaid fraction-is the most pertinent to this case. The Medicaid fraction is derived by dividing "the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [of the Social Security Act]" by the "total number of a hospital's patient days for such period." *Id.*

Before January 2000, the Secretary's policy was not to include expansion waiver patients in the Medicaid fraction. Dep't of Health & Human Servs., *Program Memorandum Intermediaries,* Trans. No. A-99-62 (Dec. 1999). Despite this policy, some financial intermediaries included the expansion waiver population in the disproportionate share hospital adjustment. *Id.* The Secretary recognized this as a violation of the stated policy but did not attempt to recover the payments. *Id.* In January 2000, the Secretary revised the policy and permitted hospitals to include the expansion waiver population in the Medicaid fraction. 65 Fed. Reg. 3136, 3139. Three years later the Secretary issued another revision, excluding the expansion waiver populations associated with certain demonstration projects likely to deal with higher income individuals. *Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates,* 68 Fed. Reg. 27,154, 27,702 (May 19, 2003).

The plaintiff hospitals based their claims on cost reports submitted before the Secretary's policy change in January 2000. The hospitals filed their cost reports with financial intermediaries and received notices of program reimbursement that did not take TennCare's expansion waiver population into account in calculating the disproportionate share hospital adjustment. Each hospital appealed to the Provider Reimbursement Review Board, and lost. *See* 42 U.S.C. § 1395oo(a). The hospitals then filed these suits, claiming that the Secretary had unlawfully refused to count TennCare's expansion waiver population in the disproportionate share hospital adjustment.

The district court granted the hospitals' motion for summary judgment, finding that the demonstration project provision and the disproportionate share hospital adjustment provision unambiguously required the Secretary to include the expansion waiver population in the Medicaid fraction. *Cookeville Reg. Med. Ctr. v. Thompson*, 2005 WL 3276219 (D.D.C. Oct. 28, 2005) (*Cookeville I*). While this case was pending appeal, Congress passed the Deficit Reduction Act of 2005.[4] The Act included a provision explicitly giving the Secretary discretion to determine whether to include a demonstration project's expansion waiver population in the disproportionate share calculation. Deficit Reduction Act § 5002(a). The Act also purported to ratify the Secretary's prior policies regarding the inclusion or exclusion of the expansion waiver population. *Id.* § 5002(b)(3)(A), (B).

In light of these provisions, the Secretary moved to alter the judgment. We remanded the case and the district court granted the Secretary's motion. *Cookeville Reg. Med. Ctr. v. Leavitt*, 2006 WL 2787831 (D.D.C. Sept. 26, 2006) (*Cookeville II*). The district court held that despite its view of the law before the Deficit Reduction Act, the Act constituted a valid retroactive change in the law. *Id.* at *6-8. On that basis the court granted summary judgment in favor of the Secretary. Our review is *de novo*. *Taylor v. Rice*, 451 F.3d 898, 904 (D.C. Cir. 2006).

The hospitals make three points. The first is that the pre-Act law unambiguously required the

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[4] Baptist Memorial's case was stayed pending the resolution of the *Cookeville* action.

inclusion of the expansion waiver patients in the disproportionate share hospital adjustment, leaving the Secretary with no discretion. The second is that the Act, which acknowledges the Secretary's discretion and ratifies the Secretary's earlier policies, was therefore a substantive change in the law. The third is that the Act cannot be applied retroactively consistent with *Landgraf v. USI Film Products*, 511 U.S. 244, 265, 114 S.Ct. 1483, 128 L.Ed.2d 229 (1994), because Congress did not clearly indicate its intention to this effect.

Even if we agreed with the first two propositions, which we do not, we doubt the last. What is and what is not a retroactive application of the law is not always easy to discern. The Court's opinion in *Landgraf* indicates that a law has a retroactive effect if it "impairs [a] right[ ] a party possessed when he acted." *Id.* at 280, 114 S.Ct. 1483. While that formulation seems simple enough, the Court discusses a host of exceptions that weaken the anti-retroactivity principle. *See, e.g., id.* at 273, 114 S.Ct. 1483 (anti-retroactivity weakened in prospective relief cases), 275, 114 S.Ct. 1483 (anti-retroactivity weakened in regard to procedural rules), 277, 114 S.Ct. 1483 (anti-retroactivity does not apply when the ultimate outcome is foreseeable, explaining *Bradley v. Sch. Bd. of the City of Richmond*, 416 U.S. 696, 94 S.Ct. 2006, 40 L.Ed.2d 476 (1974)). These exceptions, especially *Bradley*, tend to show that the presumption against retroactivity exists to protect settled expectations. *See also id.* at 265, 114 S.Ct. 1483 ("Elementary considerations of fairness dictate that individuals should have an opportunity to know what the law is and to conform their conduct

accordingly; settled expectations should not be lightly disrupted.").

Here the hospitals could not have been certain of being reimbursed. The Secretary's policy during the relevant period was not to include the expansion waiver population in the disproportionate share hospital adjustment. 65 Fed. Reg. at 3136. Although some financial intermediaries were including the expansion waiver population, many (including those in Tennessee) were not. The hospitals were thus on notice that the expansion population might not be included.

In any event, we disagree with the hospitals' first proposition that the pre-Act law clearly required inclusion of the expansion waiver patients in the disproportionate share hospital adjustment. For this point, the hospitals draw most of their support from a Ninth Circuit opinion analyzing the relevant pre-Act statutes and determining that expansion waiver patients had to be included. *Portland Adventist Med. Ctr. v. Thompson*, 399 F.3d 1091 (9th Cir. 2005).[5] We believe the pre-Act law was not as clear as the Ninth Circuit thought it to be.

The Medicaid fraction incorporates patients who "were eligible for medical assistance ... under a state plan approved under subchapter XIX." 42 U.S.C. § 1395ww (d)(5)(F)(vi)(II). The Social Security Act

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[5] The hospitals could hardly claim that their actions were taken in reliance on *Portland Adventist*. They were operating outside the jurisdiction of the Ninth Circuit and the *Portland Adventist* opinion was published several years after the last of the fiscal years involved in this case.

sets out the requirements for a patient to be eligible for medical assistance. 42 U.S.C. § 1396d(a). The expansion waiver population does not meet these criteria-generally because their incomes are too high. Likewise, demonstration projects are state plans approved under subchapter XI, not subchapter XIX.

The hospitals say that expansion waiver patients must be treated as eligible for medical assistance because they receive a Medicaid benefit when the hospitals are reimbursed by Medicaid for their care. This argument stems from the language providing that the costs of a demonstration project "shall" be regarded as expenditures under subchapter XIX. *See* 42 U.S.C. § 1315(a)(2)(A). The statute, however, modifies the "shall" by indicating that the costs are only treated as Medicaid expenditures "to the extent and for the period prescribed by the Secretary." *Id.* While this clearly gives the Secretary control over the duration of the demonstration project, the language may do more. Plausibly, the "to the extent" language is a grant of discretion to the Secretary to determine which costs or how much of the costs are to be treated as expenditures.[6] Under this reading, the Secretary would have discretion to limit a hospital's reimbursement for the expansion waiver population, rather than permitting the hospital to

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[6] The House and Senate reports discussing § 1315 lend support to this reading. Both stated that the costs of demonstration projects "could be included, for purposes of such participation, as expenditures under ... the State plan approved under any of such titles, but only for the period and to the extent prescribed by the Secretary." S. Rep. 87-1589, at 31 (1962), U.S.Code Cong. & Admin.News 1962, pp. 1943, 1973; H.R. Rep. 87-1414, at 35 (1962).

seek the disproportionate share hospital adjustment. This interpretation finds some support in the Deficit Reduction Act. No one contests that § 5002(a) of the Act gives the Secretary discretion (at least prospectively) to exclude the expansion waiver population. In conferring this discretion, Congress relied on the "to the extent and for the period" language used in § 1315 regarding the demonstration projects, albeit in a different context. Deficit Reduction Act § 5002(a). Additionally, the Secretary acted as though the statute granted discretion to decide how to treat the expansion waiver population. The Secretary chose to issue policies rather than regulations and to base them on practical concerns instead of statutory constraints. *See, e.g., Program Memorandum Intermediaries,* Trans. No. A-99-62; 65 Fed. Reg. at 3136.

These considerations lead us to conclude that it was unclear, prior to the Deficit Reduction Act, whether the Secretary had discretion to exclude the expansion waiver population from the disproportionate share hospital adjustment. It follows that there is no problem of retroactivity. The Deficit Reduction Act did not retroactively alter settled law; it simply clarified an ambiguity in the existing legislation. *See* Deficit Reduction Act § 5002(a).[7] In doing so, Congress ratified the Secretary's earlier policies, "including the policy ...

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[7] *See Brown v. Thompson,* 374 F.3d 253, 257-60 (4th Cir. 2004); *Piamba Cortes v. Am. Airlines, Inc.,* 177 F.3d 1272, 1283-84 (11th Cir.1999); *Beverly Comm. Hosp. Ass'n v. Belshe,* 132 F.3d 1259, 1265 (9th Cir. 1997); *Liquilux Gas Corp. v. Martin Gas Sales,* 979 F.2d 887, 890 (1st Cir. 1992).

regarding discharges occurring prior to January 20, 2000," to emphasize that the Secretary always had this discretionary authority. *Id.* § 5002(b)(3)(A).[8] *Affirmed.*

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[8] Because the Act resolves an ambiguity in the law, there is nothing to the hospitals' claim that the Act violates the Due Process Clause. *See Beverly Comm.*, 132 F.3d at 1267.

United States District Court, District of Columbia.

BAPTIST MEMORIAL HOSPITAL, et al., Plaintiffs,

v.

Michael O. LEAVITT, Secretary, Department of Health and Human Services, Defendant.

Civil Action No. 06-00437 (JR).

June 27, 2007.

ORDER

UPON CONSIDERATION OF Plaintiffs' response to the Order to Show Cause, and it appearing to the Court that there is good cause for the relief requested, it is this 27th day of June, 2007

ORDERED, that this Court finds the decision in *Cookeville Regional Medical Center v. Leavitt*, No. 04-1053 (JR), to be controlling in this action and accordingly final judgment is entered in favor of defendant and against the plaintiffs.

s/ James Robertson
James Robertson
United States District Judge

United States District Court, District of Columbia.

COOKEVILLE REGIONAL MEDICAL CENTER, et al., Plaintiffs,

v.

Michael O. LEAVITT, Secretary, Department of Health and Human Services, Defendant.

Civil Action No. 04-1053 (JR).

Sept. 26, 2006.

MEMORANDUM

JAMES ROBERTSON, District Judge.

Pending before the court is Defendants' Motion to Alter the Judgment [28]. For the reasons set forth below, that motion would be granted if the case were remanded to this court.

Background

Plaintiffs, fifteen Tennessee hospitals, brought an action against the Secretary of Health and Human Services ("the Secretary") seeking a declaration that the Secretary's method of calculating reimbursements under the Medicare statute's disproportionate share hospital (DSH) formula, 42 U.S.C. § 1395ww(d)(5)(f)(vi), was unlawful. They also sought reimbursement they would be entitled to receive under their interpretation of the DSH formula, for services they provided to low-income patients prior to January 20, 2000 (the date the Secretary began applying the interpretation they seek). Both sides moved for summary judgment.

On September 30, 2005, I granted plaintiffs' motion for summary judgment, denied defendants' motion for summary judgment, and stated that the

reasons for the ruling, along with a remedial order, would follow. On October 28, 2005, I issued a memorandum explaining my conclusion that "the Secretary's exclusionary method of calculating the DSH adjustment that was in effect before January 20, 2005 contravenes clear and unambiguous statutes." Mem. Order at 20 [dkt. # 22]. I ordered the Secretary to instruct his fiscal intermediaries to correct plaintiffs' cost reports for the fiscal years at issue within 90 days of their receipt of the relevant documentation from the plaintiffs. Defendants appealed that ruling on December 27, 2005.

Notwithstanding that he had already appealed, the Secretary moved for the entry of final judgment on January 18, 2006, citing Rule 58 of the Federal Rules of Civil Procedure, which states that "Every judgment ... must be set forth on a separate document." Fed. R. Civ. P. 58(a)(1). On January 28, 2006, I granted the motion, stating:

The order of September 30, 2005, granting the motion for summary judgment, would ordinarily have sufficed as and for a final, appealable order, but in this case the memorandum explaining that order was not issued for another 28 days, and the later memorandum was accompanied by a remedial order. The sequencing of the court's orders was not calculated to "avoid dispute and promote certainty," and the government's confusion is understandable. The Clerk is accordingly directed to enter final judgment in favor of the plaintiff and against the government.

Order of Jan. 24, 2006 (Dk. 25). Pursuant to that order, the Clerk entered final judgment for the plaintiffs on February 2, 2006.

The February 2, 2006 judgment, which at the time seemed to be a simple matter of bookkeeping, had the convenient effect (for the government) of reopening the 10-day window for motions to alter or amend under Rule 59(e). The Secretary took advantage of this, and, on February 13, 2006, filed his motion to alter or amend the judgment based on a new statutory provision enacted five days earlier as part of the Deficit Reduction Omnibus Act of 2005 ("DRA"). Pub. L. 109-171. Section 5002 of that act, entitled "Clarification of Determination of Medicaid Patient Days for DSH Computation," amended the Medicaid provision at issue in this litigation to reflect the Secretary's position, and purported to ratify his regulations of January 20, 2000, including "the policy in such regulations regarding discharges occurring prior to January 20, 2000."

After the Secretary's Rule 59(e) motion was filed, the Court of Appeals stayed the Secretary's appeal pending resolution of the motion that is now before me. Ordinarily I would be hesitant to rule on a motion to alter a judgment while an appeal is pending. The Court of Appeals has made it clear that I am to do something with the motion, however, and accordingly, under *Smith v. Pollin,* 194 F.2d 349, 350 (D.C. Cir. 1952), I will consider the Rule 59(e) motion and indicate whether I would grant it, so that the Secretary may then ask the Court of Appeals for a remand for entry of the order.

Analysis

An extended discussion of the statutory framework governing the DSH formula appears in the October 2005 memorandum and will not be repeated here. Stated simply, the issue is whether

"expansion populations"[1] are necessarily "eligible for medical assistance under a State plan approved under subchapter XIX." 42 U.S.C. § 1395ww (d)(f)(vi)(II). The recently enacted Section 5002 of the DRA amends the DSH formula to state explicitly that such populations are *not* so eligible:

> In determining ... the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.

DRA, Section 5002(a), Pub. L. 109-171 (emphasis added). The Secretary argues that this amendment is a "clarification" of the DSH formula, rather than a substantive change, and thus, that I should revisit my conclusion about the meaning of the DSH formula in light of this Congressional input. Alternatively, according to the Secretary, even if this amendment does reflect a substantive change of the DSH formula, in Section 5002(b) Congress has now approved and ratified the Secretary's pre-2000 exclusionary policy toward expansion populations.

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[1] *I.e.*, patients who would not otherwise be eligible for Medicaid but who become eligible solely because of the Secretary's waiver of certain Medicaid program requirements as part of a demonstration project under 42 U.S.C. § 1315a.

That section, entitled "Ratification and Prospective Application of Previous Regulations," states:

> (1) IN GENERAL-[R]egulations described in paragraph (3), insofar as such regulations provide for the treatment of individuals eligible for medical assistance under a demonstration project approved under title XI of the Social Security Act under section 1886(d)(5)(F)(vi) of such Act, are hereby ratified, effective as of the date of their respective promulgations.
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> ...
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> (3) REGULATIONS DESCRIBED-For purposes of paragraph (1), the regulations described in this paragraph are as follows:
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> 1. 2000 REGULATION-Regulations promulgated on January 20, 2000, at 65 Federal Register 3136 et seq., *including the policy in such regulations regarding discharges occurring prior to January 20, 2000*.

DRA, Section 5002(a), Pub. L. 109-171 (emphasis added).

Plaintiffs raise a number of challenges to this motion. First, they argue that the Secretary's motion was untimely. Second, they argue that the DRA was unconstitutionally approved without passing both houses of Congress, and thus is not law. Third, they argue that the DRA changes rather than "clarifies" the Medicare statute, and that the change either does not apply retroactively to the cost reports at issue or violates their due process rights if it does. Finally, they argue that the Secretary's decision, even if lawful, was nevertheless arbitrary and

capricious. Each of those challenges is discussed below. None is successful.

Timeliness of the Secretary's motion

The hospitals argue that the ten-day period of limitations on Rule 59(e) motions began to run, at the very latest, with the entry of the memorandum order of October 28, 2005, setting forth the reasons for the September 30 order and remanding the matter to the Secretary, because that order fixed the rights and obligations of the parties with regard to the current dispute, "end[ing] the litigation on the merits and leav[ing] nothing for the court to do but execute the judgment." *Gulfstream Aerospace Corp. v. Mayacamas Corp.*, 485 U.S. 271, 275 (1988). The Secretary, in his memorandum to the Court of Appeals supporting the appeal of that order, stated that "the October 28 order constituted a judgment pursuant to Rule 54(a) because it is a final 'order from which an appeal lies.'" Secretary's Opposition to Plaintiff's Motion to Dismiss Appeal, at 7 (quoting Fed. R. Civ. P. 54(a)). Plaintiffs make much of this apparent admission by the Secretary of the finality of the October 28 order.

Entertaining the instant motion, filed 97 days after the "final" order of October 28, 2005, does offend the spirit of Rule 59(e)'s ten-day limit, but it does not violate the letter of that rule. Judgment must be entered on a separate document under Rule 58 before time for an appeal can run out, but the separate document rule is not such a categorical imperative that it cannot be waived, *Bankers Trust Co. v. Mallis*, 435 U.S. 381, 384 (1978), as, perhaps, by an appellee's acquiescence in an appeal taken *before* a judgment becomes final. It seems intuitively correct that taking an appeal would cut off an

appellant's right to seek amendment of the judgment appealed from, but plaintiffs have not supported that intuitive argument with case law. My conclusion, accordingly, is that the Secretary's appeal of the October 28 order did not preclude his insisting that judgment on a separate document was required before time began to run on his other post-judgment options, including his option to move under Rule 59(e). Moreover, of course, if the October 28 order is deemed not to have been a final order after all, because it was supplanted by the later judgment issued on February 2, 2006, then the status of the appeal may be in question, but the Rule 59(e) motion is certainly timely.

The constitutionality of the DRA

Plaintiffs next challenge the constitutionality of the DRA based on Congress's failure to pass identical versions of the bill in both houses. The predecessor to the DRA, S.1932, was passed by the Senate in a slightly different form than the version passed by the House of Representatives. Despite this discrepancy, the leaders of both houses attested that their respective chambers had passed the Senate version of S.1932, which the president signed into law as the DRA. Because the version of S.1932 signed by the president was not in fact the version passed by the House, plaintiffs argue, enforcement of the DRA violates the bicameral requirement of Art. I § 7 of the Constitution.

This argument fails in light of *Marshall Field & Co. v. Clark,* 143 U.S. 649 (1892). In that case, the Supreme Court established the rule that courts may not second-guess Congress's attestation as to what bills it has passed:

> The signing by the speaker of the house of representatives, and by the president of the senate, in open session, of an enrolled bill, is an official attestation by the two houses of such bill as one that has passed congress.... And when a bill, thus attested, receives his approval, and is deposited in the public archives, its authentication as a bill that has passed congress should be deemed *complete* and *unimpeachable*....The respect due to coequal and independent departments requires the judicial department to act upon that assurance, and to accept, as having passed congress, all bills authenticated in the manner stated; leaving the courts to determine, when the question properly arises, whether the act so authenticated, is in conformity with the constitution.

Id. at 672 (emphasis added).

Plaintiffs and amicus curiae point to *U.S. v. Muñoz-Flores*, 495 U.S. 385 (1990), in which the Supreme Court struck down a law that had originated in the Senate in violation of the origination clause requiring bills for raising revenue to originate in the House. In that case, the Court looked beyond Congress's designation of the relevant bill as "H.J. Res. 648," indicating the bill's origin in the House,[2] and made its own determination that the bill actually originated in the Senate. However, the Court explicitly stated that its analysis was

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[2] The designation "H.J. Res." is a standard abbreviation for "House Joint Resolution." *See Muñoz-Flores*, 495 U.S. at 409 (Scalia, J. dissenting).

different from the analysis in *Marshall Field,* which concerned the "nature of the evidence" a court should consider in deciding whether a bill had actually passed Congress. 495 U.S. at 391 n. 4. In *Muñoz-Flores,* unlike *Marshall Field,* a "constitutional requirement binding Congress" was at stake. *Id.*

Plaintiffs urge that the bicameral clause is just such a "constitutional requirement binding on Congress," and that a statute passed in violation of this requirement may be struck down under the *Muñoz-Flores* framework. The argument is a sound one, as far as it can go-a bill that does not pass both houses in the same form is not good law, no matter what the president does-but, under *Marshall Field,* it comes to an abrupt stop with the attestation of the leadership of both houses of Congress that they did pass the bill in question.

The effect of the DRA

In the memorandum explaining my original judgment, I stated that "the DSH formula unambiguously includes all patients eligible for medical assistance under Title XIX, regardless of the mechanism by which they become eligible." Mem. of October 28, 2005 at 20. Moreover, I found that the statutory scheme clearly and expressly included expansion populations among those made eligible for medical assistance under Title XIX. The 109th Congress, disagreeing, issued what it called a "clarification" now explicitly stating that expansion populations are "not so eligible." DRA, Section 5002(a). The Secretary argues that this was the true meaning of the DSH formula all along, and that my understanding of the statutory language was incorrect. Alternatively, the Secretary argues that

the DRA must be applied retroactively to overrule my ruling.

Before reaching the question of whether the DRA was a "clarification" of or a substantive change to the DSH formula, I should note plaintiffs' argument that the law of the case doctrine prevents this court, at this stage, from accepting the DRA as a clarification. The law of the case doctrine is the prudent observation that "the *same* issue presented a second time in the *same* case in the *same* court should lead to the *same* result." *Kimberlin v. Quinlan*, 199 F.3d 496, 500 (D.C. Cir. 1999). Plaintiffs cite *McCreary v. Ofer*, 1 F. Supp. 2d 32, 36 (D.D.C. 1998), for the proposition that the first step in analyzing whether a statutory amendment is a "clarification" is whether the existing law is ambiguous. Pl.'s Opp. at 14. Because that question was answered by my first opinion, which described the DSH formula as unambiguously including expansion populations, plaintiffs argue that I am now constrained to find the DRA to be a substantive change in the law.

The Secretary's multiple filings never offered a cogent response to this argument or, indeed, even appeared to grasp it, as evidenced by his statement that the law of the case doctrine "would not only preclude this Court from considering the new statute, but would also preclude the Court of Appeals from passing on the question." Def.'s Reply Mem. at 5. The doctrine applies to the same *court*, and the Court of Appeals is, of course, not bound by my conclusion that the original DSH formula was unambiguous.

Nevertheless, it is not clear to me that the question of whether pre-amendment law is "settled," *McCreary*, 1 F. Supp. 2d at 36, is identical to the

question of whether it is "unambiguous[ ]" under *Chevron USA, Inc. v. Natural Resources Defense Council,* 467 U.S. 837, 842 (1984). In *Beverly Community Hosp. Ass'n v. Belshe,* 132 F.3d 1259, 1266 (9th Cir. 1997), for example, the court noted that although four different circuits had pronounced the Medicare provision at issue to be unambiguous under *Chevron,* none of them expressed the same construction of the statute. With so many interpretations endorsed by different courts, the Ninth Circuit did not feel the need even to look to the statute before accepting Congress's statement that its subsequent amendment was a clarification. *Id.* This suggests some play in the joints between *Chevron's* ambiguity analysis and *McCreary's* and *Beverly's* approach to pre-amendment law.

Accordingly, I will decline plaintiffs' invitation to rely upon law of the case. It matters little, however, because I remain of the view that the DSH formula, as it existed at the time of the cost reports at issue, expressly included expansion populations. That formula referred to all patients eligible for Title XIX medical assistance, and expansion populations' medical expenses are reimbursed from funds allocated under Title XIX. The DRA's insertion of the phrase "not so eligible" into the formula did not "clarify" this simple equation-it simply changed it. *See U.S. v. Montgomery County, Md.,* 761 F.2d 998, 1003 (4th Cir. 1985) ("[A] statute which has all along unambiguously proclaimed WHITE cannot retrospectively be made to assert BLACK just because the legislature, at the later date, says so.")

The Secretary's arguments to the contrary rely not on exegesis of the original language of the DSH formula as now illuminated by the DRA, but solely

on deference to Congress's later statement on the matter. The Secretary points to Supreme Court and other appellate decisions teaching that "[s]ubsequent legislation declaring the intent of an earlier statute is entitled to great weight in statutory construction." *Loving v. United States*, 517 U.S. 748, 769-70 (1996). *See also Brown v. Thompson*, 374 F.3d 253, 259 (4th Cir. 2004) ("In determining whether an amendment clarifies or changes existing law, a court, of course, looks to statements of intent made by the legislature that enacted the amendment."); *Piama Cortes v. American Airlines, Inc.*, 177 F.3d 1272, 1284 (11th Cir. 1999) ("[C]ourts may rely upon a declaration by the enacting body that its intent is to clarify [a] prior enactment."); *United States v. Sepulveda*, 115 F.3d 882, 885 n. 5 (11th Cir. 1997); *Liquilux Gas Corp. v. Martin Gas Sales, Inc.*, 979 F.2d 887, 890 (1st Cir. 1992) (using "legislature's expression of what it understood itself to be doing" to determine whether new legislation is a clarification.).

There is considerable irony in the Secretary's reliance on the *Loving* line of cases and his exhortation that I assign "significant" and "great weight" to the DRA. His reply to plaintiffs' opposition to his original motion for summary judgment included an entire section entitled "The Language ... of Subsequent Statutes Cited by Plaintiffs is Irrelevant." Defs.' Reply at 11. That section was a response to plaintiffs' citation of two subsequent enactments in which Congress, contrary to the Secretary's current view, interpreted the DSH formula to *include* expansion populations. *See* Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13581 (defining "Medicaid beneficiary" as "an individual entitled to benefits under a State

plan for medical assistance under title XIX (*including* a State plan operating under a Statewide waiver under section 1115.).") (emphasis added); Balanced Budget Act of 1997, Pub.L. No. 105-33 § 4403(b)(3) (defining the DSH calculation as "including ... individuals who receive medical assistance under such title pursuant to a waiver by the Secretary under section 1115."). The Secretary dismissed these statues as the "irrelevant understanding of the 103d [and, presumably, 105th] Congress," Defs.' Reply at 13 n. 8, and cited the "canons of statutory construction," *id.* at 11, that "[L]ater-enacted laws ... do not declare the meaning of earlier law," *Almendarez-Torres v. United States,* 523 U.S. 224, 237 (1998), and "the view of a later Congress cannot control the interpretation of an earlier enacted statute." *O'Gilvie v. United States,* 519 U.S. 79, 90 (1996). Why the view of the 103rd and 105th Congresses should be irrelevant for purposes of statutory construction, while that of the 109th should be of "great weight," is a mystery the Secretary has failed to explain. Whatever significance should be given to later legislation declaring the meaning of an earlier statute, at the very least, *conflicting* Congressional enactments purporting to interpret the same statute ought to cancel each other out, particularly when the statute at issue is as clear and unambiguous as the original DSH formula.

Although it is clear to me that the DRA makes a substantive change to the DSH formula and is not a "clarification," it is equally clear that Congress did intend this change to apply retroactively. In reaching this conclusion, I am mindful of the heavy presumption in the law against the retroactive

application of statutes and the rule that courts will only apply a law retroactively if there is a clear statement in the statute requiring that result. *See Rivers v. Roadway Express,* 511 U.S. 298, 307-310 (1994). I find such clarity for two reasons. First, Congress's titling of Section 5002 as a "clarification" is strong evidence of its retroactive effect. A clarification is a statement "of what [Congress] believed the law already was, and thus to be applicable to all cases, past, present and future." *Means v. Northern Cheyenne Tribal Court,* 154 F.3d 941, 951 (9th Cir. 1998) (J. Reinhardt, concurring); *see also Beverly,* 132 F.3d at 1264 ("Congress' characterization [of a new act as a clarification] plainly reflects its intention to resolve every still-live dispute in the manner specified by the new legislation."); *Department of Toxic Substances Control v. Interstate Non-Ferrous Corp.,* 99 F. Supp. 2d 1123, 1133 (E.D. Cal. 2000) ("Repeated use of the word 'clarification' ... is clear, unambiguous, and commanding evidence in favor of retrospectivity."). Second, Congress included an express ratification of the Secretary's conduct in § 5002(b) of the DRA. That section ratifies "[r]egulations promulgated on January 20, 2000 ... including the policy in such regulations regarding discharges occurring prior to January 20, 2000."

Regarding the ratification provision, plaintiffs argue that there is no mention of any policy regarding pre-January 20, 2000 discharges in the text of the regulations. But it is evident that Congress was referring to the pre-2000 exclusionary policy described in the Secretary's commentary to the January 20, 2000 regulations. The plaintiffs also assert, relying on *Thomas v. Network Solutions, Inc.,*

1998 WL 1738180, *3 (D.D.C. 1998), *aff'd*, 176 F.3d 500 (D.C. Cir. 1999), that in order for a ratification to be effective, Congress must "express its clear recognition of the illegal nature of the [agency action], and its explicit intent to ratify that [action]." That may be true in the tax context of the *Thomas* case, but it makes little sense here to require Congress to recognize agency action as illegal if Congress does not agree that it was. Insisting on such a requirement would hamstring a Congress that genuinely disagreed with a court's view of an earlier statute: Congress would be unable to "clarify" what the statute meant, because the court would call that a substantive change; and it would be unable to ratify the actions at issue, because it would have to deem them illegal, something it does not believe. The DRA's double-barreled approach to this conundrum-"clarifying" the DSH formula while "ratifying" agency action that, if Congress were right, would not need to be ratified-resolves this problem by giving the court two paths to the same result. Whether as a clarification or a ratification, the DRA's expression of the DSH formula must be retroactively applied to still-pending cases.

The path to that result chosen by this court-retroactive ratification-raises what plaintiffs, in a footnote, perceive as a constitutional question. It is not the case, however, that "retroactivity would violate the due process clause of the Fifth Amendment to the United States Constitution." Pls.' Opp. at 20 n. 16. *See Association of Bituminous Contractors, Inc. v. Apfel*, 156 F.3d 1246, 1255 (D.C. Cir. 1998) (economic legislation is accorded a "'presumption of constitutionality' that can be overcome only if the challenges establishes that the

legislature acted in an arbitrary and irrational way."); *Adams v. Hinchman*, 154 F.3d 420, 424 (D.C. Cir. 1998) (even assuming statute had given federal employees a property interest in earning overtime for services already rendered, "any such property interest could be extinguished so long as the retroactive economic legislation met the guarantees of due process"). Those who operate in regulated fields like Medicare and Medicaid "'cannot object if the legislative scheme is buttressed by subsequent amendments to achieve the legislative end.'" *Connolly v. Pension Benefit Guar. Corp.*, 475 U.S. 211, 227 (1986) (quoting *FHA v. The Darlington, Inc.*, 358 U.S. 84, 91 (1958)).

The Administrative Procedures Act (APA)

Plaintiffs argue, finally, that even if the DRA retroactively endorses the Secretary's policy excluding expansion populations from the DSH formula, his decision to exclude them was arbitrary, capricious, and unreasonable, and therefore unlawful. 5 U.S.C. § 706(2)(A). The plaintiffs rest their argument on the reasons given by the Secretary for changing from an exclusionary to an inclusionary policy toward expansion populations in his January 20, 2000, promulgation. Rehashing these reasons, plaintiffs state "there is no rational connection between the findings of the Secretary, all of which support the inclusion of those populations, and the decision by the Secretary to exclude those populations with respect to the hospitals in Tennessee." Pls.' Opp. at 30.

It is not surprising, of course, that there is little connection between the Secretary's pre-2000 policy and the findings he announced in the regulation *changing* that policy. That does not mean that there

were no reasons for the prior policy, however. The Secretary has cited the most obvious reason for his prior exclusionary policy, namely, that expansion populations may have higher incomes than traditional Medicaid beneficiaries, and thus may be a poor proxy for the needy patients the DSH formula is intended to represent. That is reason enough to uphold the prior policy under the APA.

Conclusion

Because the DRA changed the law regarding the calculation of Medicare reimbursements under the DSH formula, and because that change applies retroactively, the court would **grant** the Secretary's Motion to Alter the Judgment [28] should this case be remanded from the United States Court of Appeals for the District of Columbia Circuit.

United States District Court, District of Columbia.

COOKEVILLE REGIONAL MEDICAL CENTER, et al., Plaintiffs,

v.

Tommy G. THOMPSON, Secretary, Department of Health and Human Services, Defendant.

No. Civ.A. 04-1053 JR.

Oct. 28, 2005.

MEMORANDUM ORDER

ROBERTSON, J.

Plaintiff hospitals brought this action against the Secretary for Health and Human Services, alleging the wrongful denial of Medicare reimbursements for services they provided to low-income patients in years prior to 2000. They sought a declaration that the Secretary's interpretation of the Medicare statute's disproportionate share hospital (DSH) formula is contrary to law, and they sought reimbursement for the difference between the payments they received and the amounts they would be due under their interpretation of the DSH formula. Both parties moved for summary judgment. On September 30, 2005 I granted plaintiff's motion for summary judgment and denied defendant's cross-motion. The reasons for this order are set forth below.

Background

This case is significantly more difficult to describe than to decide. It involves a dispute between fifteen Tennessee hospitals and the Secretary for Health and Human Services over the meaning of discrete provisions for payments made

under the Medicare program, which reimburses hospitals for inpatient services to Medicare-eligible patients. 42 U.S.C. §§ 1395c*etseq*. Medicare uses a "prospective payment" system (PPS) for reimbursement. 42 U.S.C. § 1395ww(d). Hospitals are credited with fixed amounts for defined "diagnosis-related groups," and these amounts are then subject to a variety of hospital-specific adjustments. This dispute is about the correct calculation of one such adjustment.

In 1986, Congress authorized a PPS adjustment for hospitals that serve "a significantly disproportionate number of low income patients ..." 42 U.S.C. § 1395ww (d)(5)(F)(i)(I). It did so after determining that low-income patients tend to consume a disproportionately large share of hospitals' resources, resulting in higher per-case Medicare costs. H.R. Rep. No. 99-241 at 16 (1986), *reprinted in* 1986 U.S.C.C.A.N. 579, 594. The amount a hospital receives under this provision is calculated using a "disproportionate share hospital" (DSH) percentage, which in turn is derived from a statutory formula that compares the number of patient days a hospital devotes to low-income patients with its total number of patient days. *See* 42 U.S.C. § 1395ww (d)(5)(f)(vi).

Rather than specify a particular income threshold for its definition of "low income," the DSH formula uses eligibility for Medicaid as a proxy for low-income status. Using this proxy, the statute defines "disproportionate share percentage" as the sum of two fractions: the Medicare low-income fraction, which is not at issue in this case, and the Medicaid fraction, which is. The Medicaid fraction is defined as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter [the Medicaid program], but who were not entitled to benefits under [Medicare Part A], and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(f)(vi)(II). The most significant aspect of this definition, for purposes of this case, is the requirement that Medicaid patients be "eligible for medical assistance under a State plan approved under [Title] XIX" in order to be included in the DSH calculation. 42 U.S.C. § 1395ww (d)(5)(f)(vi).

Title XIX of the Social Security Act (Medicaid) authorizes the use of federal funds to help states offset the cost of providing medical assistance to eligible low-income individuals. *See* 42 U.S.C. § 1396 *et seq.* To receive these funds, a state must submit a "state plan" for approval by the Secretary, and it must administer the plan according to Medicaid requirements. 42 U.S.C. § 1396d(a). These requirements regulate the manner in which the plan is implemented (*e.g.*, requiring the plan to be statewide rather than limited to urban areas), as well as which individuals may be covered. See 42 U.S.C. § 1396a. Only expenditures made under an approved Medicaid state plan become eligible for matching federal payments. 42 U.S.C. § 1396d (a)-(b).

State plans must ordinarily meet the requirements of the Medicaid statute (Title XIX) to

receive funding. However, Congress has authorized the Secretary, through Section 1115 of subchapter XI of the Social Security Act, to approve "experimental, pilot, or demonstration projects" that go beyond these requirements in order to promote innovative approaches to meeting the health care needs of low-income individuals. 42 U.S.C. § 1315. These projects must, in the judgment of the Secretary, be "likely to assist in promoting the objectives of ... [Title] XIX." 42 U.S.C. § 1315a. The Secretary may waive the Medicaid requirements set forth in 42 U.S.C. § 1396a for these demonstration projects, and the costs of such projects "shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under [Title XIX]."42 U.S.C. § 1315a(1)-(2).

As a result of these § 1115 waivers, states sometimes receive matching Medicaid payments for patients who otherwise would not have been eligible for medical assistance under Medicaid. These patients, referred to by the government as "expansion populations," are at the center of the dispute between the hospitals and the government in this case.

Before January 2000, the Secretary interpreted the DSH formula as excluding patients made eligible for Title XIX matching payments solely through a § 1115 waiver. Because of regional inconsistencies among its fiscal intermediaries in the treatment of expansion populations,[1] however, the Secretary

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[1] Fiscal intermediaries act as the Secretary's agents in his dealings with Medicare service providers. The intermediaries review annual cost reports submitted by hospitals and issue a

Continued on following page

issued an interim rule in January 2000 clarifying the Department's position. *See* Interim Final Rule, 65 Fed.Reg. 3136, 3137, 3139 (Jan. 20, 2000). The Secretary explained that patients who receive medical assistance under a demonstration project fall into two categories: "hypothetical eligibles," who would be eligible for Medicaid assistance with or without a § 1115 waiver; and "expanded eligibility groups," who became eligible solely because of the waiver. *Id.* The Secretary made it clear that agency policy *before* the issuance of the interim rule had been to include "hypothetical eligibles" in the DSH calculation, but to exclude "expanded eligibility groups." *Id.*

Having clarified the agency's past interpretation of the DSH formula, the Secretary then used the same interim rule to reverse his policy and to announce that, in future calculations, *all* patients receiving medical assistance under § 1115 waiver programs would be included in the DSH formula, including expansion populations. *Id.* at 3136-37. The Secretary acknowledged that "[o]ne of the purposes of a section 1115 expansion waiver is to extend Title XIX matching payments to services furnished to populations that otherwise could not have been made eligible for Medicaid." *Id.* The Secretary stated that the inclusion of persons made "eligible for Title XIX matching payments under a section 1115

Continued from previous page

"Notice of Program Reimbursement" explaining the amount of reimbursement a hospital may receive. Before 2000, some intermediaries used expansion populations to calculate a hospital's DSH percentage, while others followed the Secretary's policy of excluding them.

waiver" was "fully consistent" with the goals of the DSH adjustment. *Id.* While not applying this rule retroactively, the Secretary stated that hospitals that had erroneously been allowed by fiscal intermediaries to include expansion populations in their DSH calculations would be held harmless. *Id.* The interim rule-excluding expansion populations from DSH calculations before January 2000, and including them thereafter-was subsequently made final, 65 Fed. Reg. 47,054 (Aug. 1, 2000).

Procedural History

Plaintiffs are fifteen not-for-profit Tennessee hospitals that participate in Medicare and Medicaid through the "TennCare" program. TennCare is a state plan operating under a § 1115 waiver that provides medical assistance to uninsured and underinsured patients, many of whom do not fit Medicaid's traditional eligibility requirements. Prior to 2000, each hospital submitted its DSH adjustment request to the Secretary's fiscal intermediary, and each hospital's DSH adjustment was reduced by the exclusion of expansion populations. Plaintiffs filed timely appeals to the Provider Reimbursement Review Board (PRRB), but also requested expedited judicial review because their appeal involved "a question of law," which the PRRB lacks authority to decide. 42 U.S.C. § 1395oo(a). The PRRB granted that request, giving plaintiffs 60 days to file a civil action, and plaintiffs then timely filed this action. They sought (1) a declaration that the Secretary's former interpretation of the Medicare PPS statute, by excluding expansion populations from the DSH adjustment formula, contravenes the clear language of the statute; and (2) an order requiring the

Secretary to recalculate plaintiffs' DSH percentage using the correct formula and directing the Secretary to pay plaintiffs the amounts unlawfully withheld from their DSH adjustment, with interest.

Discussion

Judicial review of an agency's interpretation of a statutory scheme it administers has two steps. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984). First, the reviewing court looks to the statutory language and legislative history to determine if Congress has directly spoken to the precise question at issue. *Id.* Clear Congressional intent must be given effect, and an agency's inconsistent interpretation is not entitled to deference. *Id.* If the statute is silent or ambiguous, the reviewing court proceeds to the second *Chevron* step, where "the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Id.* A court cannot substitute its judgment for an agency's reasonable interpretation of a statute in the absence of unambiguous Congressional intent. *Id.*

This case lies at the intersection of two statutes: the DSH formula, 42 U.S.C. § 1395ww(d)(5)(F)(vi), and the § 1115 waiver provision, 42 U.S.C. § 1315. The Secretary contends that these statutes are ambiguous or at least silent on the question of whether the DSH provision includes Medicaid patients eligible for medical assistance only because of a § 1115 waiver. I find, however, that "the statutory scheme is coherent and consistent," *Barnhart v. Sigmon Coal Co., Inc.* 534 U.S. 438, 450, 122 S.Ct. 941, 151 L.Ed.2d 908 (2002) (citing

Robinson v. Shell Oil Co., 519 U.S. 337, 340, 117 S.Ct. 843, 136 L.Ed.2d 808 (1997)) and that "the language at issue has a plain and unambiguous meaning with regard to the particular dispute in the case." *Id.*

In defining its proxy for low-income patients, the DSH formula directs the Secretary to include all "patients who ... were eligible for medical assistance under a State plan approved under [Title] XIX." § 1395ww(d)(5)(F)(vi). And, in defining the relationship between demonstration projects and the Medicaid program as a whole, § 1115 dictates that the "costs of [demonstration] projects ...*shall*, to the extent and for such period prescribed by the Secretary, be regarded as expenditures under the State plan approved under [Title] XIX." 42 U.S.C. § 1315 (emphasis added). If the costs of a § 1115 demonstration project must be regarded as part of "a State plan approved under [Title XIX]," as § 1115 mandates, then patients whose treatment is funded by such expenditures must be "eligible for medical assistance under a State plan approved under [Title] XIX," as the DSH formula specifies. *See Portland Adventist Med. Ctr. v. Thompson*, 399 F.3d 1091, 1098 (2005) ("Use of the term 'shall' creates a mandatory equivalence between expenditures under a § 1115 project and Title XIX expenditures.") It follows that expansion populations, no less than "hypothetical eligibles," must be included in the DSH calculation, and that the Secretary's exclusion of expansion populations from plaintiffs' DSH adjustments for fiscal years prior to 2000 contravenes the clear language of the statute.

Although there is nothing ambiguous about the language of the statutes, it is helpful that Congress

spoke quite directly to the precise issue of the relationship between § 1115 waivers and the DSH formula in a later statute. Under longstanding DSH rules, urban and rural hospitals of varying sizes face different DSH percentage thresholds before they become eligible for DSH adjustments. 42 U.S.C. § 1395ww(d)(5)(F)(v). In 1997, Congress directed the Secretary to submit a report on the viability of changing these varying thresholds into a single standard for all DSH-eligible hospitals. Pub. L. No. 105-33 § 4403(b). In its directive, Congress made it clear that the DSH formula includes the cost of providing "medical assistance under the State plan under title XIX ... (*including*... individuals who receive medical assistance under such title pursuant to a waiver by the Secretary under section 1115 ...)."Pub. L. No. 105-33 § 4403(b)(3) (emphasis added). While "the views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one," *Reno v. Bossier Parish Sch. Bd.*, 520 U.S. 471, 484-85, 117 S.Ct. 1491, 137 L.Ed.2d 730 (1997) (quoting *U.S. v. Price*, 361 U.S. 304, 313, 80 S.Ct. 326, 4 L.Ed.2d 334 (1960)), Congress, through this parenthetical, simply confirmed what was already clear from the language and structure of the § 1115 and the DSH formula.[2]

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[2] The Secretary appeared to interpret this Congressional directive in just this way. The agency's rule explains that Congress required the Secretary to submit a formula that considers "the costs incurred for furnishing services to individuals receiving Medicaid ...*including*... individuals who receive medical assistance in a State with an § 1115 waiver under Medicaid." Final Rule, 62 Fed. Reg. 45,966, 46,002 (Aug. 29, 1997) (emphasis added).

The Secretary offered two interesting, but ultimately flawed, theories for his contention that he had the authority to exclude expansion populations from the DSH formula for years prior to 2000. First, he maintained that § 1115(a)(2) provided him with "separate expenditure authority" over medical assistance to expansion populations. Def.'s Reply Memo. at 7. Second, the Secretary asserted that § 1115(a)(2) gives him the authority to regard medical assistance to expansion populations as part of a Title XIX state plan for purposes of reimbursement, but not for purposes of the DSH adjustment. Neither contention was persuasive.

A. Section 1115 and Medicaid Expenditure Authority

The Secretary argued at length in his briefs that § 1115 gives him "expenditure authority" under Title *XI* with which he funds demonstration projects, and that this "expenditure authority" is "separate" from Title XIX. *Id.* As he correctly pointed out, expansion populations cannot be made eligible for Medicaid by a § 1115(a)(1) waiver of Medicaid's requirements alone. Rather, "it is with [§ 1115(a)(2)] authority, and this authority only, that the Secretary may authorize federal dollars be used to reimburse states for providing medical assistance to 'expansion populations' ..."*Id.* at 8. Because § 1115 is part of subchapter XI of the Social Security Act, and not subchapter XIX, the Secretary went on to argue that a demonstration project is "indisputably a creature of Title XI, approved by the Secretary pursuant to § 1115 ..., and *not* approved under 42 U.S.C. § 1396a, § 1396b, *or any other provision of Title XIX." Id.* at 10 (emphasis in original).

The Secretary's contention that § 1115(a)(2) gives him "separate expenditure authority" is refuted, however, by the language and structure of Title XIX and XI. The DSH formula requires the inclusion of all patients who are "eligible for medical assistance under a State plan approved under [Title XIX]."42 U.S.C. § 1395ww (d)(5)(F)(vi). "Medical assistance" is defined in Title XIX as "payment of part or all of the cost of ... care and services ... for individuals ... whose income and resources are insufficient to meet all of such cost...."42 U.S.C. § 1396d(a). The Secretary is only authorized to provide medical assistance "under a state plan," and only expenditures made under a state plan are eligible for Title XIX payments. *See* 42 U.S.C. §§ 1396, 1396d(a)-(b); *Portland Adventist,* 399 F.3d at 1097-98. Section 1396a spells out certain requirements for state plans, including populations they *must* serve, and § 1396b provides for the reimbursement of states for a portion of the costs of providing medical assistance under the state plan. Section § 1396b also prevents federal reimbursement for patients who fall outside of the eligibility rules of the state plan.

These provisions defining medical assistance and laying out the conditions for federal matching payments make it clear that Title XIX is the source and vehicle of federal authority for providing medical assistance under Medicaid. Nothing in § 1115 creates a similar scheme of medical assistance or authorizes appropriation of any sums for funding demonstration projects. As the Ninth Circuit wrote in *Portland Adventist,* "When Congress has established separate funding sources, it has done so with specific language." 399 F.3d at 1097-98, citing

42 U.S.C. § 301 (authorizing appropriations for state "old-age assistance" plans) and § 1396 (authorizing appropriations for Medicaid payments to states). This is no less true for demonstration projects funded under independent appropriations. *Id.*, citing 42 U.S.C. § 300z-9 (authorizing appropriations for adolescent family life demonstration projects). There is no independent authorizing language in § 1115, demonstrating that Congress did not consider § 1115 to be a funding source. Rather, the purpose of § 1115 is to empower the Secretary to waive certain restrictions on state plans so that they may become eligible for *Title XIX* funds. Indeed, even this authority is conditioned on the Secretary's determination that such a waiver "assist[s] in promoting the objectives of [Title] XIX." 42 U.S.C. § 1315(a).

The Secretary took pains to avoid the text of § 1115(a)(2) when he defined his "separate expenditure authority" as the authority to specify that state expenditures for demonstration projects "'shall be regarded as' matchable for the purpose of providing federal funding." *Id.* at 8 (quoting 42 U.S.C. § 1315). But what follows the half-quoted clause, "shall be regarded as," is, "expenditures under the State plan approved under [Title] XIX." 42 U.S.C. § 1315. Rather than establishing an independent authority to direct federal spending, this and the other operative parts of § 1115 explicitly define the Secretary's authority by reference to *Title XIX*.It is clear that expansion populations become eligible for medical assistance only under a state plan approved under Title XIX, not a separate § 1115 funding mechanism. *See Portland v. Adventist,* 399 F.3d at 1097 ("Neither this provision nor any other

authorizes appropriation of any sums for purposes of funding projects approved under § 1115.")

There is a further problem with the Secretary's contention, of course, namely, that it contradicts his current practice, in force since January 2000, of *including* expansion waiver populations in the DSH calculation. When he announced the current policy, the Secretary stated that "[o]ne of the purposes of a section 1115 expansion waiver is to extend Title XIX matching payments to services furnished to populations that otherwise could not have been made eligible for Medicaid." *See* Interim Final Rule, 65 Fed.Reg. 3136, 3137, 3139 (Jan. 20, 2000). He also stated that including persons made "eligible for Title *XIX* matching payments under a section 1115 waiver" was "fully consistent" with the goals of the DSH adjustment. *Id.* (emphasis added). But in his argument justifying his previous exclusion of expansion populations, the Secretary called demonstration projects (and the medical assistance they provide) "indisputably [ ] creature[s] of Title XI, approved by the Secretary pursuant to § 1115 ..., and *not* approved under 42 U.S.C. § 1396a, § 1396b, *or any other provision of Title XIX.*" Def.'s Reply Memo. at 10 (emphasis in original).

The Secretary cannot have it both ways. Medical assistance provided to expansion populations is either part of a state plan approved under Title XIX, or it is not. If the medical assistance provided through demonstration projects indeed flows from a "separate [Title XI] expenditure authority," as the Secretary maintained, it would contravene the statute to include expansion populations in the DSH formula no less than it would to exclude them if such assistance flows from Title XIX, as plaintiffs claim.

Thus, the only way the Secretary's pre-2000 exclusionary policy could have been lawful is if his current policy of inclusion were unlawful. Even the ambiguity the Secretary purported to find in the statutes could not embrace two contradictory policies.

B. The Secretary's "Extent and Period" Discretion

The Secretary's second justification for his prior exclusion of expansion populations from the DSH statute rested on the language of § 1115(a)(2), which provides that the cost of demonstration projects "shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan ... approved under [Title XIX]."42 U.S.C. § 1315(a)(2)(A). The Secretary claimed that this provision gives him "broad discretion to treat [demonstration project] expenditures as Medicaid expenditures only to the extent of determining Medicaid reimbursement to a state, but not for the further purpose of calculating the DSH adjustment." Def.'s Reply Memo. at 13.

Such a reading rips the "extent" and "period" language from its context, and unjustifiably turns it into an expansive grant of authority unmoored to any statutory scheme. As the Ninth Circuit explained, the "'extent' and 'period' language, following and modifying the mandatory term 'shall,' plainly ... refers to the lifespan of a the project-the period during which the equivalence between § 1115 and Title XIX expenditures is required." *Portland Adventist,* 399 F.3d at 1098. In other words, the Secretary may determine the period of time for which demonstration project expenditures will be reimbursed under Title XIX, and also to what extent those expenditures will be reimbursed under Title

XIX. But, once he makes those determinations, he has no choice but to treat the costs as expenditures under a Title XIX state plan. *See Hewitt v. Helms*, 459 U.S. 460, 471, 103 S.Ct. 864, 74 L.Ed.2d 675 (1983) ("Shall" is "language of an unmistakably mandatory character"). No other reading does justice to the structure and plain language of § 1115.

It is noteworthy that the very same language appears in § 1115(a)(1), which grants the Secretary the authority to waive certain state plan restrictions "to the extent and for such period as [the Secretary] finds necessary to enable such State or States to carry out [a demonstration] project." 42 U.S.C. § 1315(a)(1). The Secretary did not maintain that this language means anything other than that he may carve out certain exceptions to Title XIX's state plan requirements for the duration of the demonstration project. That is, he did not claim that this authority gives him the ability to prevent an approved demonstration project from being included in the DSH calculation.

Instead, the Secretary attempted to distinguish § 1115(a)(1)'s "extent" and "period" clause from that in § 1115(a)(2) by pointing to the first clause's addition of the language, "he finds necessary to enable such State or States to carry out such project." 42 U.S.C. § 1315(a)(1). Because this language is absent from § 1115(a)(2), which deals with program costs, the Secretary argued that the clauses cannot mean the same thing. He pointed to *Hohn v. United States*, 524 U.S. 236, 250, 118 S.Ct. 1969, 141 L.Ed.2d 242 (1998), which states, "[W]here Congress includes particular language in one section of a statue, but omits it in another section of the same Act, it is generally presumed that Congress

acts intentionally and purposefully in the disparate inclusion or exclusion." The Secretary then claimed that a permissible reading of § 1115(a)(2)'s use of "extent" and "period" is one that grants him the authority to regard demonstration project expenditures as part of Title XIX state plans for purposes of providing matching federal payments, but "to decline to further regard them as Medicaid expenditures for purposes of the Medicare DSH provision." Def.'s Reply Memo. at 13-14.

This conclusory leap is unsupported by the statute. The Secretary's insistence that the deletion of the "carry out" language in § 1115(a)(2) must be regarded as purposeful is well taken, but an obvious purpose presents itself: such language is useful when dealing with § 1115(a)(1)'s waiver of programmatic regulations (such as whether a program must operate state-wide, or which patients it must serve), but unnecessary when dealing with the reimbursement of state payments for the program once it is up and running (as § 1115(a)(2) does). A particular Medicaid requirement may doom a potential demonstration project unless it is waived, but whether a State receives Title XIX matching payments *after* it has carried out a project cannot affect its ability to carry the project out in the first place. For this reason, additional language is unnecessary to spell out § 1115(a)(2)'s grant of authority to the Secretary to determine which costs, over which periods, are expenditures that will be eligible for matching Title XIX funds.

There is simply no statutory support for the proposition that the Secretary can pick and choose how to characterize the costs of demonstration projects, regarding them as expenditures under a

Title XIX state plan for purposes of reimbursement, but not for the DSH calculation (or, for that matter, any other statute that references Title XIX state plans). Under § 1115(a)(2), the Secretary may decide, consistent with "the objectives of [Title] XIX," the extent to which the costs of a demonstration project should be regarded as reimbursable expenditures under a Title XIX state plan. Once he makes this decision, however, the DSH formula requires that patients served by such a project be counted as part of a hospital's DSH adjustment. *Cf. Her Majesty the Queen in Right of Ontario v. U.S. E.P.A.*, 912 F.2d 1525, 1533 (D.C. Cir. 1990) ("The words 'whenever' the Administrator 'has reason to believe' imply a degree of discretion.... Once [a] finding is made, however, the ... action that follows is both specific and mandatory-the Administrator 'shall' notify the Governor of the specific State ...").

Conclusion

The plain language of the DSH and § 1115 waiver provisions, the statutory scheme of medical assistance under Medicare, and Congress's subsequent statements on the matter lead me to the conclusion that the DSH formula unambiguously includes all patients eligible for medical assistance under Title XIX, regardless of the mechanism by which they become eligible. This includes those patients who would not otherwise have been eligible for Medicaid but for the § 1115 waiver provision. I therefore find that the Secretary's exclusionary method of calculating the DSH adjustment that was in effect before January 20, 2000 contravenes clear and unambiguous statutes. Because I find that Congress has spoken clearly through these statutes, I do not need to address whether the Secretary's

policy was a "permissible" interpretation of the statute. *Chevron U.S.A., Inc.*, 467 U.S. at 843.

The Secretary must instruct his fiscal intermediaries in Tennessee to correct each of plaintiffs' cost reports for the fiscal years at issue, reflecting the inclusion of all Medicaid-eligible patients excluded under the prior invalid policy. Any increased DSH adjustment payments to which plaintiffs are due under this calculation must be delivered to plaintiffs within 90 days of the receipt by the Secretary's intermediary of all relevant documents by each plaintiff. These payments shall include an award of interest pursuant to 42 U.S.C. § 1395oo(f)(2). This case is remanded to the Secretary for a resolution consistent with this order.

It is SO ORDERED.

Social Security Act, 42 U.S.C. § 1395ww(d)(5)(f)(vi)(II) (prior to the enactment of the Deficit Reduction Act Of 2005, Pub. L. No. 109-171, § 5002(a))

Prior to enactment of the Deficit Reduction Act Of 2005, Pub. L. No. 109-171, § 5002(a), the Medicaid fraction of the Medicare disproportionate share hospital adjustment was defined as follows:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter [the Medicaid program], but who were not entitled to benefits under [Medicare Part A], and the denominator of which is the total number of the hospital's patient days for such period.

Social Security Act, 42 U.S.C. § 1315(a)

(a) Waiver of State plan requirements; costs regarded as State plan expenditures; availability of appropriations

In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of subchapter I, X, XIV, XVI, or XIX of this chapter, or part A or D of subchapter IV of this chapter, in a State or States--

(1) the Secretary may waive compliance with any of the requirements of section 302, 602, 654, 1202, 1352, 1382, or 1396a of this title, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and

(2) (A) costs of such project which would not otherwise be included as expenditures under section 303, 655, 1203, 1353, 1383, or 1396b of this title, as the case may be, and which are not included as part of the costs of projects under section 1310 of this title, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such subchapter, or for administration of such State plan or plans, as may be appropriate, and

(B) costs of such project which would not otherwise be a permissible use of funds under part A of subchapter IV of this

> chapter and which are not included as part of the costs of projects under section 1310 of this title, shall to the extent and for the period prescribed by the Secretary, be regarded as a permissible use of funds under such part.

In addition, not to exceed $4,000,000 of the aggregate amount appropriated for payments to States under such subchapters for any fiscal year beginning after June 30, 1967, shall be available, under such terms and conditions as the Secretary may establish, for payments to States to cover so much of the cost of such projects as is not covered by payments under such subchapters and is not included as part of the cost of projects for purposes of section 1310 of this title.

Deficit Reduction Act Of 2005, Pub. L. No. 109-171, § 5002

SEC. 5002. CLARIFICATION OF DETERMINATION OF MEDICAID PATIENT DAYS FOR DSH COMPUTATION.

(a) IN GENERAL.--Section 1886(d)(5)(F)(vi) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(vi)) is amended by adding after and below subclause (II) the following:

"In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.".

(b) RATIFICATION AND PROSPECTIVE APPLICATION OF PREVIOUS REGULATIONS.--

(1) IN GENERAL. -- Subject to paragraph (2), regulations described in paragraph (3), insofar as such regulations provide for the treatment of individuals eligible for medical assistance under a demonstration project approved under title XI of the Social Security Act under section 1886(d)(5)(F)(vi) of such Act, are hereby ratified, effective as of the date of their respective promulgations.

(2) NO APPLICATION TO CLOSED COST REPORTS. -- Paragraph (1) shall not be applied in a manner that requires the reopening of any cost reports which are closed as of the date of the enactment of this Act.

(3) REGULATIONS DESCRIBED. -- For purposes of paragraph (1), the regulations described in this paragraph are as follows:

(A) 2000 REGULATION. -- Regulations promulgated on January 20, 2000, at 65 Federal Register 3136 et seq., including the policy in such regulations regarding discharges occurring prior to January 20, 2000.

(B) 2003 REGULATION. -- Regulations promulgated on August 1, 2003, at 68 Federal Register 45345 et seq.

Medicare Inpatient Disproportionate Share Hospital (DSH) Adjustment Calculation: Change In The Treatment Of Certain Medicaid Patient Days In States With 1115 Expansion Waivers, 65 Fed. Reg. 3136-01 (Jan. 20, 2000)

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period implements a change to the Medicare DSH adjustment calculation policy in reference to section 1115 expansion waiver days. This rule sets forth the criteria to use in calculating the Medicare DSH adjustment for hospitals for purposes of payment under the prospective payment system.

DATES: Effective date: January 20, 2000.

Applicability Date: These regulations are applicable to discharges occurring on or after January 20, 2000.

Comment date: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on March 20, 2000.

ADDRESSES: Mail an original and 3 copies of written comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA-1124-IFC, P.O. Box 8010, Baltimore, MD 21244-8010.

If you prefer, you may deliver an original and 3 copies of your written comments to one of the following addresses:

Room 443-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201, or

Room C5-16-03, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

FOR FURTHER INFORMATION CONTACT: Kathleen Buto, Deputy Director, Center for Health Plans and Providers, (202) 205-2505.

SUPPLEMENTARY INFORMATION:

I. Background

A. Summary

The Medicare disproportionate share hospital (DSH) adjustment provision under section 1886(d)(5)(F) of the Social Security Act (the Act) was enacted by section 9105 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 and became effective for discharges occurring on or after May 1, 1986, as set forth in the May 6, 1986 final rule with comment period (51 FR 16772).

The size of a hospital's Medicare DSH adjustment, which is applied to the hospital inpatient prospective payment system (PPS) payment, is based on the sum of the percentage of patient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI), and the percentage of patient days attributable to patients eligible for Medicaid but not Medicare Part A. The first computation includes days for patients who, during a given month, were entitled to both Medicare Part A and SSI (excluding State supplementation). This number is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. The second computation includes patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan

approved under Title XIX but who were not entitled to Medicare Part A. (See 42 CFR 412.106(b)(4).) This number is divided by the total number of patient days for that same period.

Currently, hospitals whose disproportionate patient percentage exceeds a certain threshold (which varies for urban and rural areas) receive either a fixed adjustment or, in the case of large urban hospitals (100 or more beds) or large rural hospitals (500 or more beds), a variable adjustment based on a statutory formula. As of April 1, 1990, variable adjustments were made for large urban hospitals and rural referral centers. Facilities that qualify as rural referral centers as well as sole community hospitals receive the greater of a fixed adjustment or a variable adjustment based on a statutory formula. Qualifying large rural hospitals and sole community hospitals receive a fixed adjustment. Urban hospitals with 100 or more beds that receive funds from State and local governments for indigent care in excess of 30 percent of net inpatient revenues are treated separately (42 CFR 412.106(c)).

B. Section 1115 Expansion Waivers

Some States provide medical assistance under a demonstration project (also referred to as a section 1115 waiver). In some section 1115 waivers, a given population that otherwise could have been made eligible for Medicaid under section 1902(r)(2) or 1931(b) in a State plan amendment is made eligible under the waiver. These populations are referred to as hypothetical eligibles, and are specific, finite populations identifiable in the budget neutrality agreements found in the Special Terms and Conditions for the demonstrations; the patient days

utilized by that population are to be recognized for purposes of calculating the Medicare DSH adjustment. In addition, the section 1115 waiver may provide for medical assistance to expanded eligibility populations that could not otherwise be made eligible for Medicaid.

Under current policy, hospitals were to include in the Medicare DSH calculation only those days for populations under the section 1115 waiver who were or could have been made eligible under a State plan. Patient days of the expanded eligibility groups, however, were not to be included in the Medicare DSH calculation.

II. Provisions of the Interim Final Rule With Comment Period

In this interim final rule with comment period, we are revising the policy, effective with discharges occurring on or after January 20, 2000, to allow hospitals to include the patient days of all populations eligible for Title XIX matching payments in a State's section 1115 waiver in calculating the hospital's Medicare DSH adjustment.

One purpose of a section 1115 expansion waiver is to extend Title XIX matching payments to services furnished to populations that otherwise could not have been made eligible for Medicaid. The costs associated with these populations are matched based on section 1115 authority. In fact, section 1115(a)(2)(A) of the Act states that the "costs of such project which would not otherwise be included as expenditures under section * * * 1903 * * * shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures * * * approved under (Title XIX)." Thus, the statute

allows for the expansion populations to be treated as Medicaid beneficiaries.

In addition, at the time that the Congress enacted the Medicare DSH adjustment, there were no approved section 1115 expansion waivers. Nonetheless, we believe allowing hospitals to include the section 1115 expanded waiver population in the Medicare DSH calculation is fully consistent with the Congressional goals of the Medicare DSH adjustment to recognize the higher costs to hospitals of treating low income individuals covered under Medicaid. Therefore, inpatient hospital days for these individuals eligible for Title XIX matching payments under a section 1115 waiver are to be included as Medicaid days for purposes of the Medicare DSH adjustment calculation.

In order to provide consistency in both components of the calculation, any days that are added to the Medicaid day count must also be added to the total day count, to the extent that they have not been previously so added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid as described in this rule cannot be counted.

III. Response to Comments

Because of the large number of items of correspondence we normally receive on Federal Register documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the DATES section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

IV. Waiver of Proposed Rulemaking and 30-Day Delay in the Effective Date

We ordinarily publish a notice of proposed rulemaking in the Federal Register and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

We find that it would be contrary to the public interest to undertake prior notice and comment procedures before implementing this interim final rule with comment period. States that have approved section 1115 waivers are continually involved in critical efforts to implement, refine, and operate their Medicaid programs. For example, the States, managed care organizations, and hospitals are always considering their financial positions and the adequacy of rates paid between these critical

partners. We believe this policy change impacts their financial positions. Therefore, we believe the extended period of uncertainty for hospitals and others that would result if this policy change were to go through proposed and final rulemaking could adversely affect the course of these critical efforts and thereby disrupt services to Medicaid beneficiaries and other low-income patients who are served by hospitals, especially safety net hospitals.

Moreover, because our prior guidance on certain aspects of our Medicare DSH policy was insufficiently clear, many hospitals in States with approved section 1115 expansion waivers have been receiving Medicare DSH payments reflecting the inclusion of expansion population patient days. But for an immediate effective date of this rule, these Medicare DSH payments will cease until completion of the notice and comment rulemaking process, and, as a result, many of these hospitals may experience financial difficulties that may adversely affect access to services by the low-income patients served by these safety net hospitals.

Therefore, we find good cause to waive the notice of proposed rulemaking and to issue this final rule on an interim basis. We are providing a 60-day comment period for public comment.

Also, we normally provide a delay of 30 days in the effective date of a regulation. However, if adherence to this procedure would be impracticable, unnecessary, or contrary to the public interest, we may waive the delay in the effective date. For the reasons discussed above, it is important that the provisions of this final rule with comment period have immediate effect in order to avoid a potential

hardship for hospitals and a potential disruption of services for their patients.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the Federal Register and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 412.106(b)(4) (ii) and (iii) contain information collection requirements that are subject to the PRA. The requirements are as follows:

In paragraph (b)(4)(ii), effective with discharges occurring on or after January 20, 2000, for purposes

of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

In paragraph (b)(4)(iii), the hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under paragraph (b)(4) and of verifying with the State that a patient was eligible for Medicaid during each claimed Medicaid day. We solicit comments on the burden associated with these requirements. Based upon the burden estimates received from the public, HCFA will add these new requirements and associated burden to the existing information collections entitled; "Medicaid Disproportionate Share Adjustment Procedure and Criteria" (OMB #0938-0691, HCFA-R-194, current expiration date 9/30/2002; and/or "Medicaid Disproportionate Share Hospital Payments--Institutions for Mental Disease" (OMB #0938-0746, HCFA-R-0266, current expiration date 6/30/2002.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

> Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Attn: Julie Brown, Room N2-14-26, 7500 Security Boulevard, Baltimore, MD 21244-1850.
>
> Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building,

Washington, DC 20503, Attn: Allison Herron Eydt, HCFA Desk Officer.

VI. Regulatory Impact Analysis

A. Introduction

Section 804(2) of title 5, United States Code (as added by section 251 of Public Law 104-121), specifies that a "major rule" is any rule that the Office of Management and Budget finds is likely to result in--

- An annual effect on the economy of $100 million or more.

- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or

- Significant adverse effects on competition, employment, investment productivity, innovation, or on the ability of United States based enterprises to compete with foreign based enterprises in domestic and export markets.

We estimate that the impact of this interim final rule with comment period will exceed $100 million. Therefore, this rule is a major rule as defined in Title 5, United States Code, section 804(2).

We have examined the impacts of this interim final rule with comment period as required by Executive Order 12866, the Regulatory Flexibility Act (RFA) (Public Law 96-354), and the Unfunded Mandates Reform Act of 1995 (Public Law 104-4). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net

benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, non-profit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by non-profit status or by having revenues of $5 million or less annually. Individuals and States are not included in the definition of a small entity.

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless we certify that a final rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Public Law 98-21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the hospital inpatient prospective

payment system, we classify these hospitals as urban hospitals.

It is clear that the changes being made in this rule would affect a number of hospitals, and the effects on some may be significant. Therefore, the discussion below constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

Section 202 of the Unfunded Mandates Reform Act of 1995 requires that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation). We have concluded that this rule does not impose any mandates on State, local, or tribal governments, or the private sector that will result in an annual expenditure of $100 million or more.

B. Impact of This Interim Final Rule With Comment Period

There are currently eight States with section 1115 expansion waivers (Delaware, Hawaii, Massachusetts, Missouri, New York, Oregon, Tennessee, and Vermont). Under this interim final rule with comment period, hospitals in these eight States would be allowed to include in the Medicaid percentage portion of their Medicare DSH calculation the inpatient hospital days attributable to patients who are eligible under the State's section 1115 expansion waiver. Because our policy was that these days were not allowable prior to the effective date of this interim final rule with comment period, by allowing hospitals to begin to include these days in their Medicare DSH calculation the impact will be

to increase the DSH payments these hospitals will receive compared to what they would receive absent this change.

Based on data available for the numbers of individuals covered by the expansion waiver in each of the eight States compared to the total number of individuals covered by Medicaid in each State (adjusted for utilization), we have estimated the impact of this change to be $270 million in higher FY 2000 PPS payments, (total FY 2000 DSH payments are projected to be $4.6 billion), and $370 million in FY 2001 payments. Thus the total impact of this change for the period from FY 2001 through FY 2005 is estimated to be $2.14 billion.

In accordance with the provisions of Executive Order 12866, this interim final rule with comment period was reviewed by the Office of Management and Budget.

VII. Federalism

We have reviewed this interim final rule with comment period under the threshold criteria of Executive Order 13132, Federalism. In considering this policy change, we have evaluated any potential Federalism impacts. States are already responsible as needed for providing information to hospitals and fiscal agents under current regulations. In addition, there are existing requirements for maintaining and reporting these data under the Terms and Conditions of their section 1115 demonstration agreement. Therefore, States already possess the information necessary to implement this change, and no new standards or requirements are established as a result of this change. Indeed there may be a reduction in State responsibilities since section 1115

demonstration populations will no longer have to be treated differently from other Medicaid eligibles.

In order to assist the States in making this information available to the Medicare fiscal intermediaries so they can accurately count days related to patients eligible under an 1115 waiver, we are issuing clarifying instructions to the States specifying exactly what data are to be included in the Medicare DSH calculation, and the States' role in providing this information. In addition, we are in ongoing contact with States that have waivers in order to assist and monitor the development and implementation of their waivers.

We believe this regulation meets Federalism requirements as it does not increase the burden on States and is responsive to requests from hospitals who partner with States in providing health services to needy populations.

List of Subjects in 42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For reasons set forth in the preamble, 42 CFR chapter IV, part 412 is amended as follows:

PART 412--PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

42 CFR § 412.106

2. In §412.106, republish the headings of paragraphs (b) and (b)(4), redesignate paragraph

(b)(4)(ii) as paragraph (b)(4)(iii), and add a new paragraph (b)(4)(ii) to read as follows:

42 CFR § 412.106

§412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

* * * * *

(b) Determination of a hospital's disproportionate patient percentage. * * *

(4) Second computation. * * *

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare--Hospital Insurance; and Program No. 93.774, Medicare--Supplementary Medical Insurance Program)

Dated: December 22, 1999.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Approved: December 22, 1999.

Donna E. Shalala,

Secretary.